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Nurse's Perceptions: Responsibility Attribution of Rape Victims

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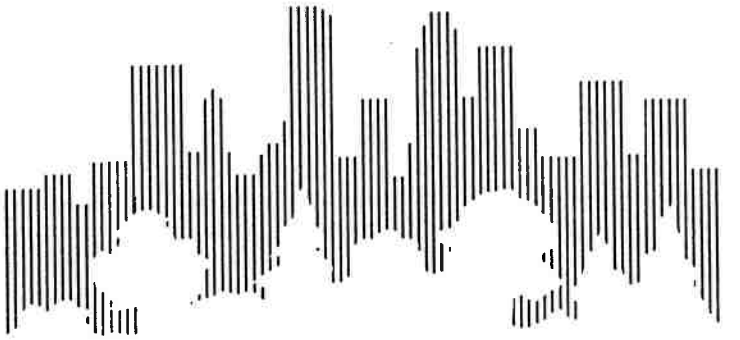

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MASTERS IN SOCIAL WORK THESIS

Barbara J. Kiffe

Nurse's Perceptions: Responsibility Attribution of Rape Victims

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ABSTRACT OF THESIS

Nurses' Perceptions: Responsibility Attribution of Rape Victims

by

Barbara J. Kiffe

August 1996

Rape is a social problem highly impacting the individuals who experience it. Social workers encounter a number of clients who have experienced sexual assault and its effects. Many clients report not only being victimized by the assault, but also in the aftermath by insensitive professionals who attribute blame to the victim. This blame is created by rape myths, beliefs that under certain circumstances, the victim was responsible for the assault. This thesis replicates a previous study conducted by Best, Dansky, and Kilpatrick (1992) in South Carolina among medical students and compares the results. This research study examines the attitudes of nurses from three different departments of a Midwestern hospital who have a high degree of contact with victims but have different levels of training and experience. Thirty-six nurses participated and were given a questionnaire consisting of three vignettes describing different rape and crime scenes accompanied by an attitude measure assessing rape myth attribution. Findings from this study indicated that the nurses accepted rape myths only to a small degree thereby attributing very little responsibility to victims. Findings also indicated that experience working with rape victims lessened the tendency to attribute blame to victims. Compared to the medical students in the Best et al. study, the nurses from the Midwestern hospital attributed less blame to victims.

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CERTIFICATE OF APPROVAL

This is to certify that the Master's thesis of:

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Nurses Perceptions: Responsibility Attribution of Rape Victims

By

Barbara J. Kiffe

A Thesis

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for the Degree

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DEDICATION

...Blunt the sharpness,
Untangle the knot,
Soften the glare...

Lao Tsu

Dedicated to survivors of sexual assault and their families. May this in some small way contribute to lessening their pain.

ACKNOWLEDGEMENTS

My acknowledgment is directed to the following people:

First of all, the many woman I was able to work with, both advocates and survivors during my years as Director of the Sexual Assault Service for Dakota County. It was my privilege during that time to not only be a part of the healing process of many survivors but to work side by side with some of the strongest, most gracious, and committed women I have ever met. Unfortunately, as one wise woman put it "All women are not our friends" and the good work had to come to an end. The goal of fighting injustice, however, burns all the brighter. It is with this intent I chose this topic both to close a chapter and to form a tribute to some of the most meaningful work of my life. For this I am thankful.

My colleagues and classmates who created interest and camaraderie, thereby greatly enhancing the course content.

My first Augsburg professors, Vincent Peters, Rosemary Link, and Glenda Rooney, whose standard of nurturing and academics carried me through the program.

Some very dear friends and prayer partners who endured my absence, stress, and occasional grouchiness.

Fred Reiter, the one constant amidst cataclysmic upheavals of change. No one should have endured quite this much challenge and without Fred it would have done me in.

Lastly, my father, Robert Kiffe, who struggled with his battle while I struggled with mine. We came to the finish line together and celebrated almost the same day. Among his last words were, "Get that thing done!" I did, Dad. Thanks.

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CHAPTER I. INTRODUCTION

STATEMENT OF THE PROBLEM

Rape has always been a common occurrence (Brownmiller, 1975), yet only recently have social scientists focused on rape-related issues. The women's movement in the early 1970s created the first ground swell of information addressing this topic. Since then, many aspects of rape have been studied, including its cause, effect and prevention. Lottes (1991) identifies three etiological models for the cause of rape: psychological, physiological, and sociocultural. Recent feminist literature, the theoretical groundwork of the paper, supports a sociocultural explanation. According to this perspective, rape is not viewed as the result of an idiosyncratic or intrapsychic problem originating in the mind of the perpetrator, but like most behavior, has been learned through interaction with others. Rape is regarded as a logical and psychological extension of a dominant ideology that degrades women and justifies coercive sexuality, and is encouraged by attitudes supporting differential power roles for men and women (Lottes, 1991; Feild, 1978; Brownmiller, 1975). Miller & Beile, as cited in Buchwald et al. (1993), state, "Sexual violence is sanctioned, at worst taught, at best excused" (p.51).

Rather than focus on the function of socialization in the development of the perpetrator, society often shifts its attention toward the behavior of the victim for a possible explanation of why an assault has been committed (Brownmiller, 1975; Burt, 1980; Feild, 1978; Thornton, Robbins & Johnson, 1981; Lottes, 1991). Attention is drawn to the victim, if not for what she did to cause the rape, then for what she could have done to prevent the assault. Often these two distinctions blur. Factors regarding the behavior of the victim prior to the assault are examined. Analyzing and assessing the victim's behaviors imply attribution of responsibility to the victim. "Responsibility attribution does not imply intentionality on the part of the victim, but rather that her behavior may be perceived as a potential contributing factor in her victimization, thereby influencing attributions of responsibility" (Thornton, Robbins, & Johnson, 1981, p. 235).

These expectations on how a woman should act in order to prevent assault create a narrow cultural definition of "real" rape. Rapes that incorporate actions on the part of the victim that people think precipitate assault such as walking at night, or accepting a drink from a stranger are not considered "real" rapes. They are "dubious" rapes and assume the victim has some responsibility in her victimization. Because people believe in rape myths they attribute partial responsibility to a victim whose assault does confirm to the narrow cultural definition of what real rape is. The assault becomes partially the victim's fault for causing it inadvertently or for not preventing it thereby lessening the guilt of the perpetrator. "Where there was 'contributory behavior' on the part of the woman - where she was hitchhiking, or dating the man, or met him at a party--juries were willing to go to extremes in their leniency toward the defendant" (Estrich, 1987, p. 5).

Victims' actions identified as contributing factors in her victimization are referred to by feminists as rape myths. Myths are defined as "prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists, which create a climate hostile to rape victims" (Brownmiller, 1975, p. 37). Both Burt (1980) and Feild (1978) operationlized rape victim prejudice by creating standardized tests consisting of commonly believed rape myths. Rape myths focus on specific aspects of the woman prior to the assault: what she did, what she wore, and with whom she slept, implying a causal relationship to the assault. Most of society has been found to believe in rape myths. "Rape myths allow people to feel safe by letting them believe rape rarely happens, and that when it does, it is because the woman secretly wanted to be raped" (Ledray, 1994, p.13).

Attribution theory, identified by Kelley (cited in Jones & Aaronson, 1973), was applied to rape incidents and tested among a number of professionals in the areas of law enforcement (Feild, 1978), mental health (Burgess & Holmstrom, 1979; Dye & Roth, 1990; Ward, 1988) and medicine (Alexander, 1980; Best, Dansky, & Kilpatrick, 1992), as well as citizens (Best, Dansky, & Kilpatrick, 1992). This theory states that for important functional and adaptive reasons, individuals attribute causality for observed behavior. They tend to look for a reason why an action occurred. Usually they attribute a certain amount of responsibility to the person involved in the action. If the action were a car accident, for instance, responsibility is attributed to the person involved in the accident. Even if one of the people in the accident was an innocent victim, that person's behavior is examined for what he or she could have done to avoid the accident thereby attributing a measure of responsibility.

In being questioned about their victimization, rape victims often describe police, health care providers, the courts, social workers and society as treating them as if they were the offender (Brownmiller, 1975; Gray, Pallileo & Johnson, 1993). The attitudes of many of these individuals, who are frequently the first to provide services to rape victims, contribute in important ways to the victim's initial self-evaluation and her subsequent recovery process (Alexander, 1980; Ward, 1988). Initial contact with the victim crucially affects her psychological adjustment to the offense. Burgess & Holmstrom (1979) found that psychological consequences can be increased or diminished, depending on the response of law enforcement and health providers. Further, harsh treatment of rape victims has been recognized by Gray, Pallileo & Johnson (1993) as a secondary victimization.

Best, Dansky, & Kilpatrick (1992) found that medical personnel hold less favorable attitudes about sexual assault victims, as opposed to non-sexual assault victims. Medical professionals often have personal belief systems about what constitutes real rape and what does not, regardless of the legal definitions of rape. Furthermore, victims who did not meet the narrow cultural expectations about how she should have behaved in order to prevent assault or not encourage it, are seen in the least positive light. This, in turn, affects the type of medical treatment victims receive (LeBourdais, 1976; Best, Dansky, & Kilpatrick, 1992). "It is conceivable that the type and amount of care provided to these patients may be affected by the victim characteristics if the medical professional is confusing his or her role as a health care provider with a judicial one" (LeBourdais, 1976 p. 13).

In recent decades, medical care has expanded to cover a variety of social ills. "The process of healing has become clogged with issues of legality and evidence, innocence and guilt" (LeBourdais, 1976). Sexual assault particularly brings up complicated legal and ethical issues. If the woman is not willing to press charges through the police, emergency departments are reluctant to provide medical treatment or follow-up care (LeBourdais, 1976). Hospital staff members resent time and money lost from their practice. They may get nervous doing their work because they fear how they will look at the hands of a defense attorney. These aspects, in addition to personal bias concerning the behaviors of the victim, further complicate the post-rape experience for sexual assault victims.

Studies assessing how professionals view rape victims indicate that most people attribute a degree of responsibility to the victim, depending on the circumstances of the assault. This has far-reaching implications for victims regarding the type and quality of service they receive from professionals, as well as how victims will deal with their assaults. Unfortunately, rape does not happen to only a handful of women. Statistics indicate that "on the average, one woman is being raped somewhere in the United States every minute of the day. One out of four women will be raped at some point in her life" (Ledray, 1994). It also is estimated that only one in ten rapes is ever reported. For fear of reprisal in a culture that subscribes to rape myths, few victims come forward. Knowing the impact rape has on victims and on our society, we can no longer tolerate such myths.

PURPOSE OF THE STUDY

Much of the literature assessing responsibility attribution among professionals was conducted throughout the late 1970s and early 1980s. Also, a large number of the studies use students as subjects. Little, if any, current research among professionals has been attempted. The purpose of this study is to update this information by examining responsibility attribution in the form of rape myth acceptance among medical personnel, specifically nurses, in relation to their training and experience. This thesis replicates a study conducted by Best, Dansky, & Kilpatrick (1992) in South Carolina among medical students and will compare results with nurses from a Midwest, urban hospital. The study examines the attitudes of practicing nurses who come in direct contact with victims to assess if the professionals attribute responsibility of the assault to the victim. This information will be useful for social work practice, policy and research.

SIGNIFICANCE FOR SOCIAL WORK PRACTICE

Rape myth acceptance creates a hostile atmosphere for the victim. While much effort has been directed toward eradicating these myths, evaluations have not determined how successful these attempts have been. One assumption is that understanding of sexual assault has increased over the years, greatly improving treatment of victims by professionals. Since the literature assessing rape attribution is dated, it is unclear if professionals still blame victims or not. In spite of training, attitudes may still remain the same as they were in the 1970s and 1980s.

In order to respectfully treat victims of sexual assault, it is important to examine the current status of rape myth acceptance and identify areas that need to improve. Results from the study indicate rape myth acceptance exists among registered nurses (RNs), and that training and experience affect acceptance. Since an estimated one in four women are raped, and the preponderance of clients social workers see are women, it is imperative social workers are aware of the society's attitudes toward victims. This awareness is particularly important for the aftermath of the assault and recovery process. Even though nurses play a vital role in the victim's recovery process, social workers can provide advocacy and support to rape victims. Social workers also can assist in changing societal conditions that lead to rape.

First respondents have a powerful impact on the victim's healing process and may affect who she will confide in afterwards, including her social worker. Medical personnel play a particularly important role in the post-rape experience; therefore, it is important that social workers know what treatment they can expect for their clients. Creating an atmosphere in which it is safer for victims to tell others may reduce the tertiary problems and destructive coping mechanisms social workers are forced to deal with when clients suppress the assault. Therefore, treating the victim respectfully from the onset is an advantage for both the client and the social worker.

RESEARCH QUESTIONS AND HYPOTHESES

The purpose of this study is so determine if nurses subscribe to rape myths and if either experience or training minimizes acceptance of these myths. This information

will be helpful for social workers in dealing with their clients in the aftermath of a sexual assault.

Research Question: What are the attitudes of nurses at a large, Midwestern hospital toward women who have been sexually assaulted?

Hypothesis: Nurses' attitudes will reflect that of other professionals, which continues to endorse some degree of rape myth acceptance.

Research Question: Does either experience with victims or sexual assault training reduce rape myth acceptance among nurses?

Hypothesis: Both training and experience will positively influence nurses' attitudes toward rape victims.

Research Question: Will the attitudes of nurses from a large, Midwestern hospital be different than the attitudes of medical students in South Carolina?

Hypothesis: Related to the hypothesis that both experience and training will positively impact nurses' attitudes, the nurses from the Midwestern hospital should demonstrate a more positive attitude because they presumably have more experience and training in working with victims, and also because they are predominately female.

Research Question: Do nurses judge rape victims more harshly than they judge other types of crime victims?

Hypothesis: Nurses will hold rape victims to higher standards of behavior than other crime victims.

DEFINITIONS

Attribution Theory: Rules regarding causal relationships between actions and events in order to understand why events occur.

Attitude: Manner, disposition, feeling or position toward a person or thing.

Blame: To place responsibility or fault on a person.

First Respondents: Professionals, including social workers, providing acute care to victims, either physically or emotionally, immediately after the assault and up to two weeks after it. This term also refers to whomever the victim initially discloses the assault whatever the time frame.

Gender: Biological sex as male or female.

Gender Role: Distinguishing behaviors, duties , or expectations of individuals based on their gender.

Nurses or Nursing Staff (mentioned in relation to the study): Registered nurses (RNs).

Rape/Sexual Assault: Threatening or physically forcing a person into participating in sexual acts against her will. Sexual acts include oral and anal intercourse or vaginal intercourse by a penis or object other than a penis. Forced sexual intercourse is penetration, no matter how slight, into a woman's vagina by a penis, finger or object. (All references of sexual assault in study refer to rape).

Rape Culture: "A set of beliefs that members of a social collectivity hold about rape, its causes, and the relative responsibility attributed to assailants and victims" (Gray, 1993, p. 378).

Rape Myths: "Prejudicial, stereotyped, or false beliefs about rape, rape victims and rapists that create a climate hostile to victims" (Brownmiller, 1975, p. 37).

Responsibility Attribution: Attributing a causal relationship between actions of the victim and the crime.

Role: A behavior pattern society typically expects of a person occupying a particular position in a social system.

CHAPTER II. REVIEW OF LITERATURE

OVERVIEW

Because reactions of professionals have a significant effect on rape victims, systematic investigations regarding the nature and dimensions of attitudes toward rape victims have been vastly important. Research has been conducted among lawyers (Burgess & Holmstrom, 1979), therapists (Dye & Roth, 1990; Ward, 1988) police officers (Feild, 1978) and medical personnel (Burgess & Holmstrom, 1979; LeBourdais, 1976). Studies have typically focused on either characteristics of the victim or characteristics of the observer (people who respond to the studies). Among victim aspects that have been the subject of research are: sexual **provacativeness**, sexual history, and level of resistance. Observer characteristics have included locus of control,

past victimization, and past sexual aggression. When a sexual assault occurs, the perpetrator is seldom caught initially, so the victim becomes the focus of attention for deciding how a sexual assault occurred. Perpetrators have been studied, but seldom in the context of the immediate assault. Instead, attention is focused on the victim, who she is and what she may have done to cause the assault.

Legal and medical professionals share similar views in regard to responsibility attribution. Strong evidence exists that police (Feild, 1978) and nurses (Alexander, 1980; Burgess & Holmstrom, 1979; LeBourdais, 1979) may blame victims and endorse rape myths. Since both police officers and nurses assist with sexual assault victims, they suffer not only from exposure to trauma but also from the effects of these negative stereotypes (Dye & Roth, 1990). In working with women who have been sexually assaulted, professionals who work with victims need to examine their own feelings in order to prevent re-victimizing the victim (LeBourdais, 1979; Gray, Palileo & Johnson, 1993).

In a comparative analysis of 1,448 police, rapists, crisis counselors, and citizens, Feild (1978) utilized several standardized instruments, as well as one he developed, consisting of commonly held beliefs about victims. Feild found that police officers were comparable to counselors regarding women's resistance. Both groups agreed that a woman did not have to fight back against the rapist or receive bruises in order to prove her innocence. However, Feild found that police officers closely aligned with rapists and citizens on motivation. Both populations thought that victims had a secret desire to be assaulted. Police see rape from the rapist's point of view in thinking the victim asked

for it. "Police officers often treat victims as if they were the offender" (Feild, 1978, p.164).

A product of their sociocultural orientation, male police officers share in macho male acculturation, which demonstrates a high level of victim blame (see section on gender). Also, the rapist is not accessible; therefore, it is easier to seek causes in the victim than in the rapist (Feild, 1978). Police are more suspicious of rape victims than robbery victims because rape is a private crime with few, if any, witnesses. Highly endorsing rape myths, "police officers may only trust a victim who is a respectable part of the community, obviously physically brutalized, repulsed by sex-related questions and hysterical throughout the interview" (Feild, 1978, p.168).

Field (1978) also found that citizens demonstrated high responsibility attribution toward victims. Some perceived rape as a "game between equals with the victim as the loser" (Feild, 1978, p.155). Both Burt (1980) and Feild (1978) found that although rapists attitudes were more extreme, they and the general public held the same beliefs about violence and its justification. Burt (1980), however, reported that younger and better educated citizens revealed fewer stereotypic, adversarial or pro-violence attitudes and less rape myth acceptance. Along with Field (1978), research conducted by Dye and Roth (1990) indicated that therapists and counselors demonstrated the most extensive knowledge and favorable reactions toward victims.

In one of the few studies conducted among RNs, Alexander (1980) found that while nurses may not blame victims for dress or degree of resistance, they will assign less blame to the assailant if the victim engaged what they perceived as questionable behaviors. Alexander compared the responses of 368 police officers to 312 nurses

regarding attribution of responsibility to victims. Alexander measured the influence of such factors as marital status, evidence of resistance, and extent of injuries as well as characteristics of the participants. In direct contradiction to similar studies, Alexander (1980) found that nurses with extensive victim contact, compared with those who have little experience, blame victims more. According to Alexander (1980), "nurses who have worked with rape victims may not be the most sympathetic providers of care" (p.67). Many other factors (to be explored further), such as traditional views of women's roles, internal locus of control and risk taking, can contribute to this finding rather than just the degree of experience.

STUDY CONDUCTED BY BEST, DANSKY, AND KILPATRICK

A study conducted by Best, Dansky, and Kilpatrick (1992) was the model for the present one. The goal of the Best et al. investigation was to examine the extent to which participant characteristics influence medical students' attitudes toward rape and non-sexual assault victims. First- and third-year medical students read narratives of three types of patients -- a stereotypical rape victim, a victim of robbery, and a non-stereotypical rape victim -- and responded to an attitude questionnaire in reference to the victims in the narratives. The results of a series of ANOVAs showed that females had more favorable attitudes toward victims than males did and that medical students had more victim-blaming attitudes about a non-stereotypical rape victim than about either a stereotypical rape victim or a non-sexual assault victim. The implications of these findings were discussed with respect to service delivery for rape victims and medical school curricula.

Subjects were 215 first- and third-year medical students at the Medical University of South Carolina. The first year students (n=120) consisted of 101 males with a mean age of 24.3 years and 19 females with a mean age of 25.8 years. The third year students (n= 95) consisted of 76 males with a mean age of 26.5 years and 19 females with a mean age of 27.3 years. The students were enrolled in their core of clinical rotations. None of the first- and third-year students had direct experience with emergency room treatment of sexual assault victims.

Participants were told that the questionnaire concerned procedures frequently used in an emergency room setting. The data for this study, although published in 1992, were collected for a dissertation thesis in 1982. The overall item endorsement rate on the Rape Attitude Scale was compared with an endorsement rate obtained in a more recent university sample (Waland et al., 1991). In the 1988 sample of university women, the overall mean rate of item endorsement on the attitudinal items taken from the scale was 5.1. This can be compared with an item endorsement rate of 5.2 obtained with the current sample of medical students, which indicated that rape myth acceptance has remained relatively stable in these types of samples.

Results from the survey indicated that female medical students had a more favorable attitude toward victims (less rape myth acceptance) than did their male counterparts. Medical students generally had less favorable attitudes toward the real and dubious rape victims than toward the robbery victim. The ANOVA did yield a significant interaction effect for the Type of Patient x Gender, $F(1,205) = 4.65$, $p<.05$. There was no significant effect for year in medical school. Attitudes between the first-

and third-year students did not differ, revealing that attitudes in this study did not change as students received more medical training.

In sum, the scores from the attitude measure demonstrate that medical personnel hold less favorable attitudes about rape victims in general, as opposed to non-sexual assault victims. Furthermore, victims who do not meet the narrow cultural definition are not seen in a positive light, as with the non-stereotypic rape victim. Both female and male students were more likely to attribute responsibility for the attack to the victim and believe the victim precipitated the assault if she does not fit the cultural stereotypes of a rape victim. They also perceived the dubious rape victim was less innocent and believed she should have tried harder to resist the attack. These findings suggested that medical professional students have personal belief systems about what constitutes real rape and what does not, regardless of the legal definition of rape.

One of the limitations of the study is its cross-sectional design rather than longitudinal approach. In addition, it is possible that the findings may not apply exactly to all medical universities. Furthermore, it is possible that the results do not represent attitudes of current medical students, although rape education has yet to be added to the medical school course curriculum. In addition, the levels of endorsement on the attitude measure were similar to those found in the more recent university sample.

IMPACT ON VICTIMS

Attribution of responsibility impacts victims in a variety of ways. Unsure about how they will be perceived, victims are reluctant to report the assault and pursue criminal charges (Gray, Palileo, & Johnson, 1993; Lottes, 1991; Best, Dansky &

Kilpatrick, 1992; Brownmiller, 1975). Elements of attribution not only determine if victims will report the assault to the police, but also how it will be processed and how it will be perceived by the jury (Macrae & Shepherd, 1989). Consequently, only an estimated ten percent of all rapes are ever reported. Lottes (1991) states that rape myths lead to "unjust, inadequate, or ineffective decisions concerning arrest, prosecution, conviction and the sentencing and treatment of offenders" (p.43). Perception of the victim's responsibility not only affects the prevalence of rape reporting and trial outcomes, but also policy decisions on how victims and rapists will be treated (Ward, 1988).

As a result, offenders benefit when victims are perceived to share responsibility for the assault. According to Kelley's discounting principle (cited in Alexander, 1980), "an actor will be assigned a less causal role in an event to the extent that other plausible causes are available" (p.71). As such, it might be expected that an accused rapist will be judged less responsible for an incident to the extent that the characteristics of the victim can be brought out as an alternative explanation for the incident. Attributing responsibility to victims for the assault facilitates the commission of crime by the assailants, and allows sexually violent men to justify their behaviors (Gray, Palileo, & Johnson, 1993; Lottes, 1991).

Victims also are impacted emotionally by responsibility attribution. Most rapes meet the legal definition of rape, but not the cultural definition, by involving numerous elements that can contribute blame to the victim (Pitts & Schwartz, 1993; Estrich, 1987). Societal attitudes are thought to influence a multitude of factors in the victim's life, such as how a victim feels about herself, her general psychological adjustment following the

rape, as well as immediate and long-term post-rape behavior patterns (Brownmiller, 1975; Best, Dansky & Kilpatrick, 1992; Burgess & Holmstrom, 1979). A negative or questioning response affects the victim's self perceptions and psychological well-being, which in turn makes recovery more difficult (Best, Dansky, & Kilpatrick, 1992; Burgess & Holmstrom, 1979).).

Acceptance of rape myths can not only affect an individual's ability to process an assault, but also her decision of when to call a certain situation a rape (Burt, 1980; Brownmiller, 1975; Pitts & Schwartz, 1993; Burgess & Holmstrom, 1979).) People learn their definitions from society; therefore, the reactions of others can be extremely important in the victim's perception of the assault (Pitts & Schwartz, 1993). "Women who were more familiar with their assailants, engaged in voluntary social contact, whose assaults involved less physical violence and who trusted their assailants prior to the assault were considered more culpable for the assault by others" (Pitts & Schwartz, 1993, p. 386). Victims often use this same criteria when judging themselves. Self-blame is already prevalent in the aftermath of the assault; therefore, when others also blame the victim, victims tend not to object.

Pitts and Schwartz (1993) conducted their study among a broad range of students at a university. The sample consisted of 288 women and asked extensive questions about experience with sexual assault. The subjects were questioned regarding reactions and statements from their first respondents. In examining these responses, Pitts & Schwartz (1993) noted a distinction between characterological blame, which attributes fault for the rape to negative character traits of the victim, and behavioral blame, which ascribes blame for the rape to contributing behaviors of the

victim. Being faulted for jogging in the park would be considered behavioral blame. Characterological blame would be faulting someone for a personal seductive style of behavior. Most victims, however, do not make distinctions between the two types of blame (Pitts & Schwartz, 1993). When being blamed, victims do not separate actions from their person. A victim experiencing either type of blame feels equally at fault.

Social psychological research on the impact of rape myths demonstrates that the net effect is to deny or reduce perceived injury and to blame the victim for her own victimization (Burt, 1980; Brownmiller, 1975). "Restrictive definitions of rape supports or excuses sexual assault both in the victim's mind and in society's" (Pitts & Schwartz, 1993). This principle is particularly true in acquaintance assaults when the victim knows the perpetrator. If judgmental toward the victim's behavior, or sexual aspects of the assault, some professionals would overlook coercion or force involved and condemn the victim for participating (Burt, 1980; Estrich, 1987).

Attributing responsibility to victims impacts not only the woman who has been assaulted but women at large by prescribing a code of behavior women need to adhere to in order to avoid rape. Stating that actions on the part of the victim contributed to her assault forces women to assume responsibility for rape prevention. Rape prevention tactics, therefore, contain a "restrictive measures" factor such as: dressing more modestly, not talking to strangers, and not going out alone at night. This trend in thought evolves around the victim's causal role in her own victimization (Thornton, Robbins & Johnson, 1981; Burt, 1980; Brownmiller, 1875; Feild, 1978). Rather than enforce a code on men not to assault, women are required to behave in such a way so as not to attract assault.

ATTRIBUTION THEORY

Attribution theory concerns itself with the means by which individuals infer causes of behavior. It identifies the rules individuals use to obtain information about themselves and others in order to understand why events occur. Jones and Aaronson (1973) have observed that people will supplement information to provide an explanation even if they don't know the answer. "For important, functional reasons, the desire to know why an event has occurred is stronger than the need for accuracy" (Jones & Aaronson, p. 420, 1973). To find an answer, individuals are often satisfied with judgments based on deficient information and faulty reasoning (Alexander, 1980).

Attribution theory states that individuals will attribute causality for observed behavior, and it is one of the reasons people examine victim's behavior for answers. Individuals make decisions about who or what is responsible for behavior they have observed. Causality or responsibility is assigned either to the actor's personal description, or to external causes such as environment or chance (Gray, Palileo & Johnson, 1993; Alexander, 1980). Attribution theory suggests that "observers tend to see other people as personally responsible for their own misfortunes" (Pugh, 1983, p. 240).

DEFENSIVE ATTRIBUTION THEORY

Defensive attribution, as identified by Shaver (cited in Thornton et al 1981) states that the greater the similarity between the observer and the observed, the greater the likelihood that the observer will attribute responsibility to someone or something other

than the observed victim. Using the defensive attribution approach, individuals attribute cause for negative events in a manner so as to reduce the likelihood of their being responsible in a similar predicament. This is motivated by the need to protect self esteem and avoid future self blame (Gray, Palileo, & Johnson, 1993). Because of their greater awareness to their own susceptibility to rape, females may be more inclined to attribute cause away from the victim in the likelihood of their own victimization (Gray, Palileo, & Johnson, 1993; Thornton, B. , Robbins, M., & Johnson, 1981; Macrae & Shepherd, 1989). In addition, Gray et al (1993) found that, presumably because they are sensitive to their own vulnerability, females who take risks are more likely to empathize with rape victims. Conversely, the defensive model suggests that, because men are at less risk for assault, they attribute greater responsibility than females (Gray, Palileo, & Johnson).

Macrae & Shepherd (1989) and Alexander (1980), however, interpret defensive attribution oppositely. These authors state that the more an observer is like the victim, the more likely the observer is to attribute blame to the victim as a defense against her own vulnerability. People find it threatening to believe that chance happenings over which they have no control may affect their lives. As a consequence, to protect themselves from the idea that the same thing could happen to them, they attribute more responsibility to people who experience negative outcomes. Thus, they make a defensive attribution (Macrae et al., 1989). In Alexander's (1980) study with nurses, she found that the more the nurse saw herself as a potential victim, the greater responsibility she assigned to the rape victim. According to Alexander (1980),

"research suggests that if the fate of the victim is extremely undesirable, such as in a rape, individuals who is like the victim will be especially critical of her" (p.72).

Before any defensiveness is aroused, observers must feel a degree of similarity with the victim. This may explain why females evaluate more unfavorably victims who deviate from acceptable codes of behavior. They identify with the woman, but pass judgment in order to separate themselves. However, in all of the studies, females were by far less judgmental than males. In addition, defensive attribution, as defined by Macrae et al. (1989) and Alexander (1980) does not explain why men blame victims. Other explanations might be: lack of empathy, "just world" theory, or locus of control, rather than defensive attribution (Deitz, Blackwell, Daley, & Bently, 1982). Males could be identifying with the male and experiencing defensive attribution toward the offender rather than the victim. Victim blame on the part of males could also be a function of male privilege. By virtue of their gender, men are higher on the pecking order and find it difficult to identify with situations of oppression.

JUST WORLD THEORY

"Just world" hypothesis is an attribution theory in which victims are to blame for their circumstances. Developed by Melvin Lerner (cited in Alexander, 1980), "just world" is where justice prevails and people are thought to generally get what they deserve, or conversely, deserve what they get (Alexander, 1980; Jones & Aaronson, 1973). Negative consequences do not just happen. Negative consequences are the result of negative character or actions on part of the observer. According to the "just world" hypothesis, observers justify misfortune by attributing responsibility or fault to the

victim. Such a belief protects the believer from sensing his or her own vulnerability to similar events (Burt, 1980; Whatley & Riggio, 1993). Observers believe if people are good, bad things won't happen.

According to Gerdes et al (1993), belief in a "just world" makes it difficult for subjects to see rape as a random event. Consequently, they rated the victim as more careless and more responsible when she was assaulted by a stranger than when she was assaulted by an acquaintance. However, victims also were attributed responsibility in acquaintance assaults. While stranger assault victims were blamed more for being "careless" or "responsible" for not preventing the assault, acquainted victims were blamed for having "done something" to cause the assault. Females were found to blame the victim less than males for the immediate or earlier behavior. This is believed to be because of the female's ability to identify with the victim and to take her perspective easier than males.

Jones and Aaronson (1973) explored the "just world" principle in relation to socially acceptable people. "Just world" theory states that misfortune befalls an individual because either the person is intrinsically bad, or because the person behaved in a bad way, therefore, respectable people are seen as more likely to have caused their own misfortune because they did not deserve the misfortune as a function of their intrinsic characteristics. When a misfortune takes place, "just world" observers ask the question, "Why did this suffering occur?" The question can only be answered by inferring that the victim in some way deserved her fate, either because of her intrinsic unworthiness or because of her actual behavior. One of the implications of this is that "when a victim does not inherently merit suffering, that is, someone who is respectable,

jurors will find it necessary to attribute responsibility to the victim in order to justify her suffering" (Jones & Aaronson, 1873, p.415). Unlike findings in other studies, women were just as severe in attributing fault as were men when the independent variable was respectability.

INTERNAL AND EXTERNAL LOCUS OF CONTROL

Rotter's locus of control, as cited in Alexander (1980), which relies on the self-perception of responsibility for one's own life, provides yet another theory on why observers attribute blame. Evidence suggests a tendency for those having a greater awareness of contingencies between behaviors and outcomes (internally oriented observers) to attribute greater responsibility to the victim. Contrastly, externally oriented observers, those who perceive little correlation between their actions and behavioral outcomes, assign less blame for their fates than those who are internally controlled (Alexander, 1980). "The greater the degree of external attribution, the lesser the perceived responsibility of the actor" (p.69). Internally oriented observers, however, tend to see others as personally responsible for their own misfortunes (Pugh, 1983; Gray, Palileo, & Johnson, 1993; Thorton, B., Robbins, M., & Johnson, 1981).

Internally controlled observers prefer to think they have control over their own lives. They assume that individuals seek to maintain a more predictable environment by uncovering underlying dispositions in an actor's behavior. According to this model, if the observers attributed some causality to external events, they would have to confront their reduced control over their own fates. Therefore, their response is to attribute a high degree of responsibility to victims for the assaults (Pugh, 1983; Gray, Palileo, &

Helig, 1993; Thorton, B., Robbins, M., & Johnson, 1981). Interestingly, Thornton et al. (1981) noted that externally controlled males attributed more responsibility than the internally controlled females. This suggests that gender is a more powerful predictor of responsibility attribution than locus of control.

Gray, Palileo, & Helig (1993) examined both the defensive attribution and the locus of control models in combination with risk taking. These researchers discovered that females, presumably because they are sensitive to their own vulnerability, were more likely to empathize with rape victims, thereby confirming the defensive attribution theory. In addition, respondents, both male and female, who take chances were more likely to identify with rape victims. These findings indicate that observers who take chances they regard as reasonable will not hold others to a standards to which they themselves do not adhere.

In analyzing risk taking with locus of control, however, Gray et al (1993) discovered that observers subscribing to the internal locus of control model make the opposite interpretation even if they are risk takers. Internally controlled individuals feel they need to maintain a sense of control over their lives. Therefore, they feel victims are responsible for their situation even when taking risks. Thus, internally controlled risk takers must hold victims responsible, otherwise they would have to admit their own vulnerability since they have taken similar chances. Conversely, internally controlled males who take risks were less likely to empathize with rape victims, thus protecting their own subjective sense of invulnerability.

GENDER DIFFERENCES

Gender has been the most powerful predictor of rape victim blaming: women blame victims less than men (Deitz, Blackwell, Daley & Bentley, 1982; Gerdes, Dammann & Helig, 1988; Gray, Palileo, & Johnson, 1993; Best, Dansky & Kilpatrick, 1992; Feild, 1978; Burt, 1980). Thornton, Robbins & Johnson (1981) found that males were more likely to have thought the victim did something to provoke the assault and, therefore, were more likely to endorse rape myths than females. Studies indicate that rape myth acceptance is more prevalent among males in general and is likely to occur when certain assault and victim characteristics are present.

In addition, acceptance of interpersonal violence (Burt, 1980), sex role stereotyping (Field, 1978; Ward, 1988) and internal locus of control (Alexander, 1980; Best, Dansky & Kilpatrick, 1992) were high predictors of responsibility attribution among males. This demonstrates that particular types of individuals, rather than whole groups, are more likely to possess negative victim beliefs. Gerdes et. al. (1988) found victim blaming higher for men in the acquaintance assaults. Whatley & Riggio (1993) discovered that males place blame more than females, even when the victim is male.

Conflict exists among researchers regarding the two genders' views of the seriousness of rape and its effects on the victim. Feild (1978) found that females had a more negative view of rape and its ramifications than did males. Thornton et al (1981), however, reported that both men and women regard rape as serious. The subjects in this study did not differ according to gender in explaining the motivational factor for rape as one of power rather than sex. The study by Gerdes' et al. (1988) discovered that both men and women saw rape as a serious crime. However, the women in this study

saw the crime as more debilitating for the victim than the men did and, therefore, warranting more punishment.

A number of reasons exist for males blaming victims. As attribution theory states, an important determiner of judgment is the observer's ability to identify with the victim. Not being the target of victimization, men find it difficult to empathize, and therefore will be more judgmental. Deitz (1982) found that male subjects showed less empathy toward rape victims, and as a consequence, were affected by the victim's personal characteristics, such as attractiveness, when evaluating the incident. In comparison, females showed a high degree of empathy with the victim and were unresponsive to her characteristics. Dietz et al.(1982) found that past sexual aggression in males also is positively related to victim blaming. Interestingly, male experience with non-sexual aggression correlates with low attribution of responsibility compared to men who have participated in sexual aggression.

Gray et al found that females, in general, are substantially less likely to blame rape victims. Women were more likely to assume the perspective of the victim and did not judge her by her characteristics (Thornton, Robbins & Johnson, 1981). Women have more factual information on rape and the topic is of more personal concern. Also, males believe in a "just world" to a greater degree than females. "Men demonstrate a greater need to believe that events happen for a reason" (Whatley & Riggio, 1993, p. 508). These explanations contribute to why males blame victims more than females.

SEX ROLE STEREOTYPING

Although gender related, most researchers found responsibility attribution to be more a function of traditional roles than a function of gender (Lottes, 1991: Macrae & Shepherd, 1989; Feild, 1978). In Macrae's et al. (1989) study of sex differences in perception of rape victims, the researchers found the disparity to be more a function of sex role attitudes than that of gender. Men with traditional sex role beliefs tended to possess more acceptance of rape myth attitudes than males with a liberal or more progressive view of the female role. "Victim blame has been associated with non-egalitarian, gender role beliefs and adversarial sexual beliefs" (Lottes, 1991, p. 43). Lottes studied attitudes toward homosexuality, machoism, and female sexuality as possible correlates in victim blaming.

Males, particularly those who have been sexual aggressors, were more likely to identify with the assailant, and exhibit greater acceptance of rape myths (Lottes, 1991; Gray, Palileo, & Johnson, 1993). In Lottes' study, women reported a wider acceptance of egalitarian gender role beliefs and less acceptance of adversarial sexual beliefs. Unlike men, they also reported greater acceptance of homosexuality, less acceptance of premarital and extramarital sex, and demonstrated less acceptance of rape myths. Males' responses, however, included more acceptance of stereotyped, male-dominant, opposing roles and contrasting sexual goals for men and women. Traditional, double-standard, male-dominant sex-role beliefs correlated positively with attributing responsibility to victims (Lottes, 1991; Malmuth & Check, 1984; Gilmarten & Zena; 1985).

Russell (1982) describes how our culture's differential sex role socialization contributes both to male sexual aggression and female victimization. Traditional sex roles socialize men to be offenders and women to be victims. Women are taught not to engage freely in sexual activity or directly indicate sexual interest. Conversely, men are taught to take initiative and persist in attempts at sexual intimacy even when a woman indicates verbally she does not want sex. Sexual coercion, therefore, is seen as normal. "Rape is a logical extension of our sex role socialization process that legitimatizes coercive sexuality" (Lottes, 1991, p. 41).

TRAINING EFFECTIVENESS

Opinions differ concerning the effectiveness of training on attitudes toward rape victims among researchers. Gray et al. (1993) discovered that rape prevention education and education level, in general, influenced the participants' attitudes about rape and minimized rape myth acceptance particularly among males. "Males who had been in college longer and who reported knowledge of rape prevention were less likely to blame rape victims" (p. 380). A conclusion of Gray's research was that "perhaps there is a reason for hope that rape culture may be altered by education and knowledge about rape and its prevention" (p. 380).

Malmuth & Check (1984) also suggest that it is possible to influence attitudes by providing rape education. They report that exposing respondents to rape scenes and then debriefing them was effective in reducing rape myth acceptance. They found that inaccurate perceptions regarding rape can be rectified through increased exposure to

factual material, thereby decreasing rape myth acceptance and resulting in improved treatment by professionals.

Other social scientists, however, identified more discouraging findings regarding training. Feild (1978) discovered that a subject's factual knowledge of rape and personal acquaintance with a rape victim were not related to attitudes toward rape. Both Thornton (1981) and Alexander (1980) question the effectiveness of training based on their research of the participants in the studies. "The strength of attitudinal and personality variables such as locus of control, societal norms and rules, suggests that special, short-term sensitivity training programs given by police departments and health agencies may be of limited use" (Alexander, 1980, p. 70). For instance, if rape myth acceptance is a function of internal locus of control or sex pole stereotyping, a simple one-time training isn't going to re-wire a person's internal belief system. Since attribution depends on an empathetic or defensive base, information alone may not help (Thornton, Robbins & Johnson, 1981).

If people are culturally disposed to view events in a certain way, education alone may not be effective. Since some people are predisposed to a locus of control and to "just world" theory and sex role stereotypes, individual differences based on social learning perspective would be not amenable to simple informational influence. However, Thornton, Robbins & Johnson, (1981) state that while it may not be possible to eliminate perceptions of victim responsibility or participation, awareness of their occurrence and influence is an important step in any attempt at controlling their impact.

Non-adversarial sexual beliefs, egalitarian gender role beliefs, and non-traditional attitudes toward female sexuality counteract rape. Acceptance of non-macho

and more sensitive male personalities lessen permission and expectations of men to be the aggressor. Since sex role stereotyping and unequal gender relations are at the root of sexual assault, effective rape prevention programs are those that encourage women to take a more active role in dating by initiating dates and sharing the expenses. These actions might make the couple less likely to feel the man is entitled to sex in exchange for his efforts, and the women less likely to feel passive or powerless (Lottes, 1991). A similar, flexible and equal role for both men and women can make sexual interchanges less confusing.

LIMITATIONS OF LITERATURE REVIEW

Rape research is relatively new. Originating in the late 1960s and early 1970s, most of the studies are in their first generation of testing and have not been repeated. A groundswell of information occurred at that time and has occurred sporadically since. Although occasional studies have been conducted in the 1980s and 1990s, some of the earlier models have yet to be replicated. Earlier, groundbreaking literature is difficult to ignore in spite of the fact that society has also changed through the decades. For instance, sex roles have loosened somewhat since the 1960s, and divorce is more acceptable. If the victim were divorced, that fact may not be as inflammatory in today's society as it was in the 1960s. Through the dissemination of information, society has learned enough about sexual assault to respond more correctly. Consequently, when compiling the literature and interspersing new studies with old is like mixing apples with oranges. Rather than being significant, the conflicting results may be more a function of comparing different eras of chronologically relevant information. Earlier studies that

revealed harsh, judgmental professionals ready to attribute blame to the victim are no longer valid. Rape myth acceptance is still prevalent, but to a lesser degree.

An apparent gap in the literature is the lack of research among social workers. Literature regarding the perceptions of social workers toward victims is non-existent. Perhaps social workers are not viewed as primary responders for rape victims. More obvious in helping victims are professionals in the criminal justice system and medical professionals who are involved in the legal and medical aspects of rape. Counselors and family members would also be identified as respondents to the emotional aftermath. Hospital social workers would be involved, but perhaps more as case mangers referring victims to community resources. Sampling this population would be difficult because hospitals usually have only one or a limited number of social workers. Several hospitals that often deal with rape victims would have to be identified to obtain a large enough sample to be statistically significant.

County social workers also remain an untapped resource for this population. Social workers' primary contact with victims is after the assault and involves responding to tertiary issues such as post traumatic stress disorder (PTSD), pregnancy, sexually transmitted diseases (STDs) or maladaptive coping mechanisms. Other tertiary rape issues involving social workers can include self-destructive behaviors such as running away from home, chemical use, and suicide attempts. Often the primary cause of these behaviors is left unexamined. When a client does divulge information about the assault, however, the response of the worker is important. Having observed a pattern of self-destructive behaviors, the worker may project blame on the victim. The fact that

studies have not been conducted in this area is unfortunate and represents a significant gap in the literature.

SUMMARY

Social scientists have found a complex web of attitudes and beliefs surrounding rape in this culture. "'Real rape' is based on a general overlay of cultural beliefs that defines rape quite narrowly" (Burt, 1980, p. 221). This narrow cultural definition describes what victims are supposed to wear, how they are supposed to act and who the perpetrator is in order for the assault to be considered valid. This narrow description is based on rape myths: inaccurate beliefs about sexual assault. Victims who do not fit this narrow description and whose assaults contain elements of the rape myths, are viewed to be at least partially responsible for the assault.

People are reluctant to accept that a victim is blameless. Social scientists attribute several reasons for victim blame. Violent crimes such as rape make people feel insecure and vulnerable, especially if they may be exposed to the offense at any place or time. For these people, it is both a relief and a comfort to believe that the victim, through appearance or behavior, may have done something to precipitate or contribute to the act. Observers no longer feel as helpless or vulnerable.

Research has revealed that individuals with certain demographic characteristics are more likely to endorse rape myths (Burt, 1980; Feild, 1978). Acceptance of interpersonal violence (Burt, 198), sex role stereotyping (Field, 1978; Ward, 1988) and internal locus of control (Alexander, 1980; Pugh, 1983; Gray, Palileo, & Johnson, 1993; Thornton, B., Robbins, M., & Johnson, 1981) are high correlates with rape myth

acceptance. Attitudes are strongly connected with other deeply held and pervasive attitudes such as sex role stereotyping, distrust of the opposite sex, and adversarial sexual patterns.

Females, particularly risk takers, are substantially less likely to blame rape victims. Among males, past sexual aggression and risk taking, in association with an internal locus of control, are positively related to victim blaming. However, gender and sex role stereotyping in both sexes was proven the most powerful factor in attributing responsibility to the victim.

Rape is the logical and psychological extension of a dominant-submissive, competitive, sex-role stereotyped culture. Therefore, change will not be accomplished easily. The common view of gender relations is that of a battle in which each side tries to exploit the other while avoiding exploitation in return. Only by promoting the idea of sex as a mutually undertaken, freely chosen, fully conscious interaction can society create an atmosphere free of the threat of rape.

CHAPTER III. METHODOLOGY

RESEARCH DESIGN

This study is an exploratory research design addressing the following questions. 1.) What are the attitudes of nurses at a large, midwestern hospital toward women who have been sexually assaulted? 2.) Does either experience with victims or sexual assault training reduce rape myth acceptance among nurses? 3.) Will attitudes of nurses from a large, Midwestern hospital be different than attitudes of medical students

in South Carolina? 4.) Do nurses judge rape victims more harshly than they judge other crime victims? Quantitative information was gathered through a self-administered, questionnaire distributed to three departments of an urban hospital. Prior to the initiation of this study, approval was obtained to proceed both by the hospital's and the college's Institutional Review Boards.

SUBJECT SELECTION

Since the nurses' previous experience with victims of violence was of particular interest, the number and types of victims served by the hospital were important considerations in the site selection. An urban hospital was selected because of the large number of sexual assault victims it serves. Three departments within the hospital were identified as having extended contact with victims initially after the assault. These departments were the Emergency Department (ED), the Crisis Center (CC), and Sexual Assault Resource Services (SARS), which consists of RNs who, instead of doctors, conduct the evidentiary exams. Nurses (RNs) were selected as a specific population with similar training, duties and responsibilities within a hospital setting. Nurses in each of the three departments function in different roles with victims, and have varying degrees of exposure to victims and different levels of sexual assault training.

DATA COLLECTION INSTRUMENT

In replicating the study conducted by Best, Dansky, & Kilpatrick (1992), the instrument was a self-administered questionnaire and consisted of a packet of materials distributed to the participants. Each packet contained the following measures:

hypothetical patient narratives, an attitude measure consisting of a combined version of Burt's (1980) Rape Myth Acceptance Scale (RMA) and Feild's (1978) Attitudes Toward Rape Scale (ATR), and a personal information sheet.

Patient Narratives

Hypothetical narratives were created by Best et al. (1992) to present clinical descriptions of three emergency room patients. The three patient descriptions were similar with respect to personal attributes, but differed in two ways: the presenting complaints (or reasons for seeking the medical treatment), and the terms of their pre-trauma behaviors. The victims portrayed in the narratives were female because the majority of adult rape victims treated in the emergency room are female.

One patient narrative, referred to as a "real" or culturally acceptable rape victim (patient 1), describes the prototypic rape victim: a young, attractive woman who was emotionally distressed by a sexual assault perpetrated by a stranger in a parking lot. The second narrative, called the "non-sexual" assault (patient 2), describes a young, attractive woman who was robbed of her purse in the parking lot. Including this narrative allows for comparison of a sexual assault with a non-sexual crime. The third narrative, the "dubious" rape victim (patient 3), portrays a young woman who did not appear distressed by the rape, which was perpetrated by a man she had met previously through the personal ads. The events depicted in the narrative for the "dubious" rape meet the legal definition for a rape, but do not fit the narrow, cultural definition and were not labeled as a sexual assault by the woman in the narrative. The three narratives are presented in Appendix C.

Attitude Scale

The attitude scale (Appendix C) was designed by Best et al. (1992) to assess rape myth acceptance in reference to each of the three narratives. Scale items were taken from the Rape Myth Acceptance Scale (RMAS; Burt 1980) and the Attitude Toward Rape Scale (ATRS; Feild, 1978), both of which are standardized. The items chosen relate specifically to the narratives. The attitude scale consists of 14 statements about the victim in the patient narrative or about women in general. Ten of the 14 statements represent rape myths; the other four (items 4, 3, 7, and 11) are fillers, not myths, and are reversely scored. All the statements are rated on a 7-point Likert scale depicting degree of agreement (1= strongly agree to 7= strongly disagree). Higher scores indicate less acceptance of rape myths. Participants completed one rating scale for each patient narrative, and a total score for each of the three scales was calculated.

Personal Identification Sheet

The personal identification data sheet (Appendix C) was used to collect demographic information. The following information was obtained on this measure: department within hospital, number of years worked in the department, and year he or she graduated from nursing school. In addition, participants also were requested to provide information about experience working with sexual assault victims and

specialized training in sexual assault treatment. Gender identification was not included. Because of the low number of male participants, the Augsburg IRB determined identification would create a risk to participants.

ETHICAL PROTECTION

Participants were advised that involvement in this study is completely voluntary and would in no way affect current or future relationships with Augsburg College or the hospital where information was gathered. Participants were told that if they participated, they were free to withdraw at any time without affecting these relationships. The identity of both the participant and the hospital would be kept anonymous. A cover letter (Appendix B) accompanied the data collection instrument explaining the purpose of the study and delineating protection. The option of a specified drop off site or a self-addressed, stamped envelope further insured anonymity.

DATA COLLECTION PROCEDURE

Directors of the three participating units of the hospital facilitated this process. A brief announcement explaining the survey was made during shift changes on a specified day for one of the departments. A similar explanation was dispensed at a staff meeting for the second department. Questionnaires were distributed after the announcements. Depending on time constraints, participants completed the questionnaire at that time, or completed and returned it later. For the third department, which did not routinely meet either for staff meetings or shift changes, the questionnaire

with cover letter was left in the participants' mailboxes. A self-addressed stamped letter was available.

Three different departments within the hospital were surveyed. The potential number of nurses to be accessed from the three departments was a total of 90 RNs. However, on the days allotted to conduct the study, only 36 nurses were working or available to participate. Utilizing three different departments required three different data collection procedures (as mentioned above). When the participants were accessed directly by the principle investigator during the shift change and allowed to immediately complete and turn in the questionnaire, the completion response was 100 % of the participants present.

The respondents approached during the staff meeting participated in a mixed return technique. Most were able to complete and return the survey before leaving. Three respondents requested to fill out the questionnaire later and return by mail. Participants from the third department received in their mailboxes a total of 15 questionnaires attached to return envelopes. These 15 participants also were allowed to mail back the survey in addition to the previous 3. Only 7 of the 18 surveys were returned through the mail.

In addition, not all returned surveys were completed. Because of the sensitive nature of the topic, the Augsburg IRB requested respondents be allowed to skip questions or discontinue the survey at any time if they felt uncomfortable. For whatever reason, one respondent submitted an incomplete questionnaire, which was then discarded. Another respondent did not fill out a personal data sheet rendering the rest of the survey futile, and it was discarded. One respondent identified two answers for

several questions, even though the answers contained a range for the data requested. The principal investigator determined that one of the two answers appeared to be faintly crossed out and determined the other answer to be the respondent's choice.

Of the 52 surveys distributed, 38 were returned, with two discarded for incompletion. This represents a 73% return rate. Since 38 RNs out of a possible 90 participated, this represents 38% participation rate. Out of the 38 returned surveys, 2 were discarded for reasons explained above. Although a total of 36 questionnaires were used in the survey, data reflects lesser numbers at times for certain responses because of limitations in the data collection tool, which will be explained later.

CHAPTER IV. FINDINGS

SOCIODEMOGRAPHICS

The respondents were RNs from an urban, midwestern hospital. Eleven nurses graduated under 10 years ago. Ten nurses graduated between 10 and 20 years ago and ten nurses graduated between 20 and 30 years. Three graduated over 30 years ago but under 40. The remaining 3 respondents are not reflected in this category because they had graduated over 40 years ago, an answer not included in this survey. The respondents were identified by neither their age, race, ethnicity nor gender.

DATA ADDRESSING RESEARCH QUESTIONS

In addressing the primary research question, "What are the attitudes of nurses at a large, mid-western hospital toward women who have been sexually assaulted?", findings indicate that the nurses, to some degree, did endorse rape myth acceptance. These findings support the hypothesis: "nurses' attitudes will reflect that of the larger population which continues to endorse rape myth acceptance." The findings from this study were consistent with those of previous studies which report that professionals demonstrate some degree of rape myth acceptance and attribute responsibility to victims. However, rape myth acceptance was very slight in comparison to previous surveys. Overall, the nurses in this study did not demonstrate a high degree of rape myth acceptance. This is demonstrated by the fact that all the tables start at number 4, which is past the midway point on the graph (Tables 1,2, and 3).

In the following graphs, each of the bars represent a respondent. The nurses' responses for the two types of victims are compared again each other and the difference is depicted by the bar. The last bar, inverted at the far right end is the average amount of difference is attitudes toward the two types of victims. A quick glance at this bar in all three tables reveal the findings that "real" rape victims are attributed less responsibility than "dubious" rape victims and that robbery victims were attributed even less responsibility than the others.

TABLE 1 **DIFFERENCE BETWEEN "SPURIOUS" & "REAL" RAPE VICTIM SCORES**

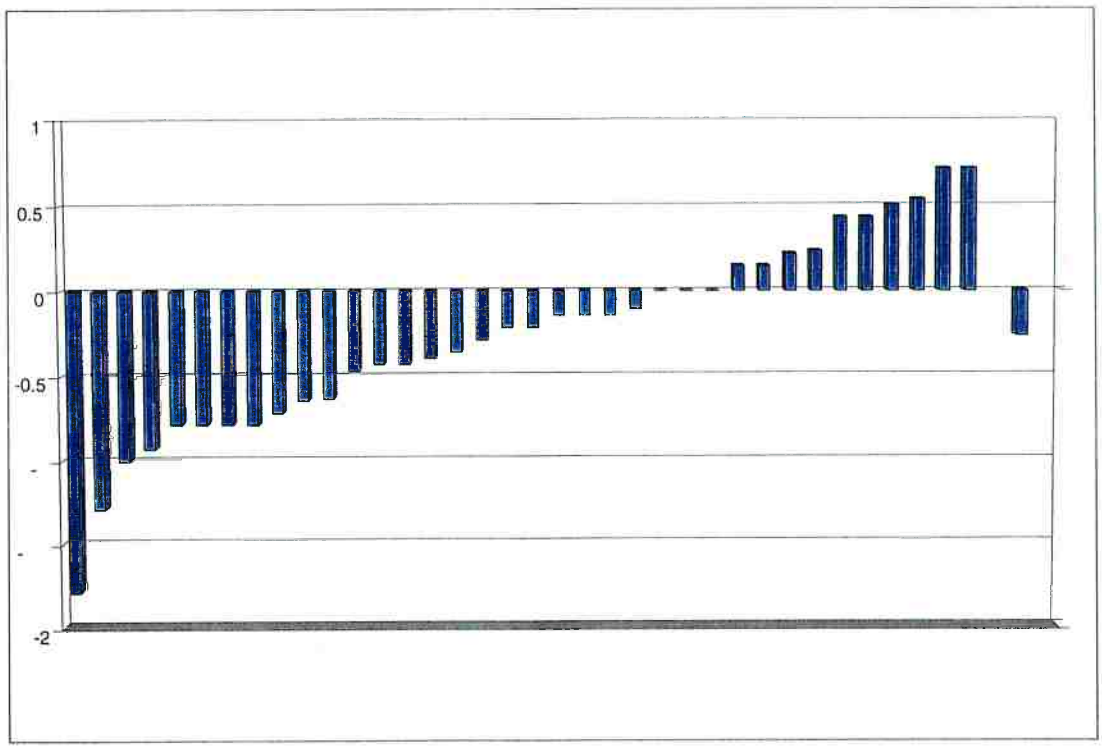


TABLE 2 **DIFFERENCE BETWEEN "SPURIOUS" RAPE & ROBBERY VICTIM SCORES**

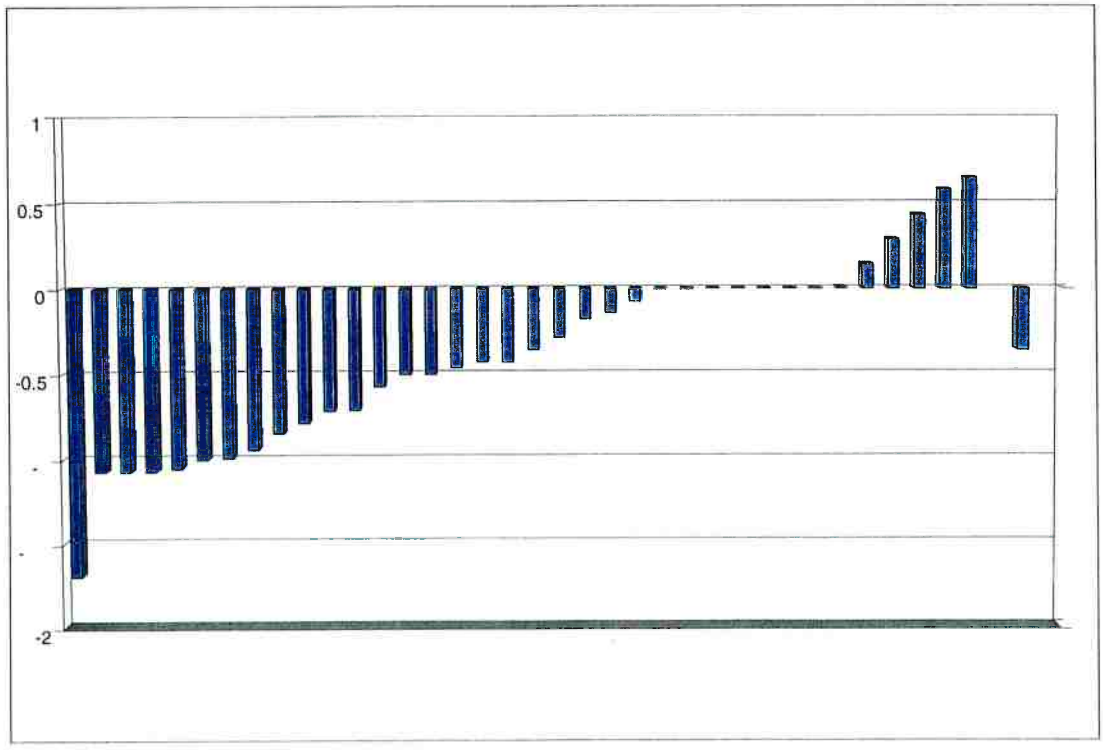
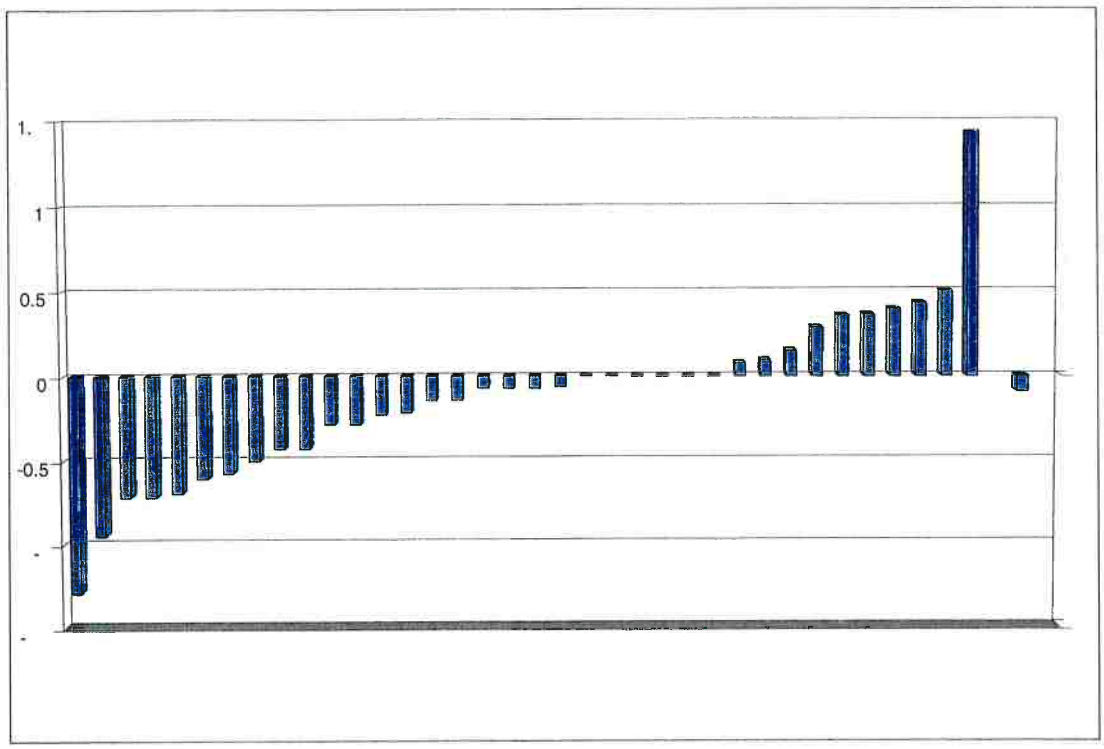


TABLE 3 **DIFFERENCE BETWEEN "REAL" RAPE & ROBBERY VICTIM SCORES**



In answering the second question, "Will attitudes of nurses from a large, mid-western hospital be different from attitudes of medical students in South Carolina?", this study again supported the principle investigator's hypothesis. The nurses in this sample scored considerably than the medical students in the Best et al. survey indicating that the nurses demonstrated less rape myth acceptance than the medical students. The nurses scored a 6.1 in this study compared to the 5.1/5.2 of the medical students in the South Carolina study. It is difficult to determine exactly to what this difference can be attributed.

In answering the third question, "Do nurses judge rape victims more harshly than other types of crime victims?", this study confirmed both the investigator's hypothesis and the findings from the literature. The nurses in this study judged the

rape victims harsher than they judged the robbery victim. They attributed more myths or attributes of responsibility toward the rape victims than they did the robbery victim. The nurses also judged the "dubious" rape victim (the one incorporating the most myths into the vignette) harsher than they judged the "real" rape victim. Only two nurses in this study judged each of the victims (robbery, "dubious", and "real") equally: a nurse who had treated 78 victims, and one who had treated 178 victims (Tables 1,2, and 3).

Results addressing the fourth question, "Does either experience or training reduce rape myth acceptance among nurses?" are mixed. In the questionnaire, experience among the nurses was identified in three ways. One method was for the nurses to identify how many years it has been since they had graduated from nurses' training (Table 4). The second method was to ask nurses how many years they had worked in the department (Table 5). The third method of identifying experience, and perhaps the most directly related, was asking the nurses to approximate how many victims they worked with in the last three years (Table 6).

In regard to the number of years since graduating, nurses with increasing years of experience demonstrated lessening acceptance of rape myths. Nurses only 1-4 years out of nursing school had lower scores (but still above the midway point) which indicated greater acceptance of rape myths. From the eight year point until 30 years of experience, rape myth acceptance remains between the 6.0 and 6.5 level indicating that additional years in the field decreases victim blaming. A total of 26 nurses were represented in this range.

After the 30 years of experience point, one nurse scores a perfect 7 and 2 of the nurses' scores dropped considerably. This demonstrates a higher rape myth

acceptance especially toward the dubious victim which is a score of 5. Although this represents just two respondents, why this occurred or its significance is difficult to determine but will be discussed later.

This category also attempts to measure generational cohort in which nurses graduating at the same time demonstrate the same attitudes. This is an indicator they were subject to the same cultural influences and received the same type of training regarding victims at the time they attended school. An erroneous assumption (and a limitation) in measuring the years since graduation is that the RNs are continually working during this time and are, therefore, gaining inexperience. This may not be true. The nurses may not have worked the entire time and, therefore, may not have gained in experience. Rather than being a measure of experience, this may just measure generational cohort (Table 4)

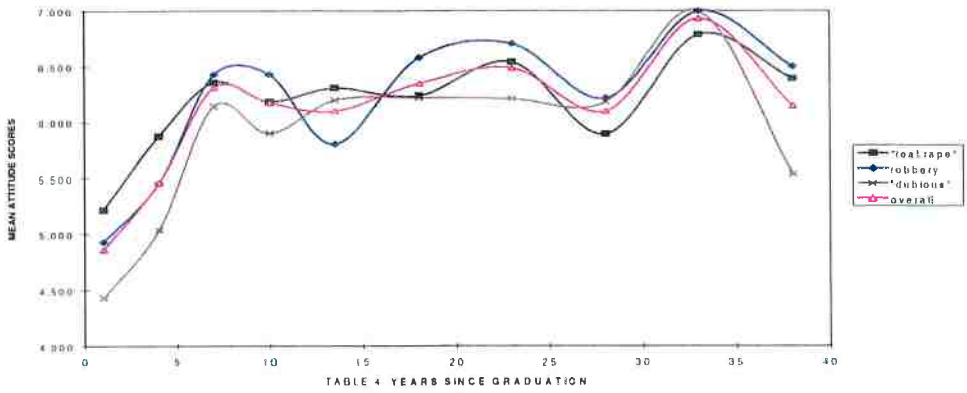
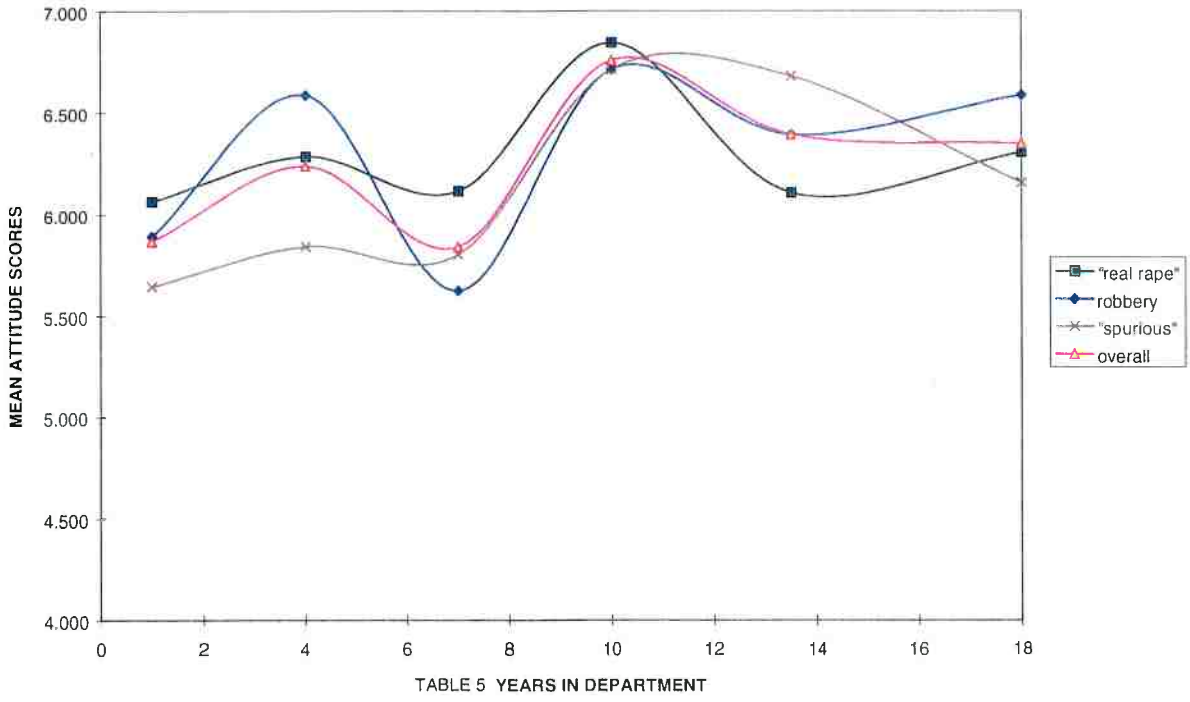


TABLE 4 YEARS SINCE GRADUATION

Number of years worked in the department were also inconclusive. Years in the department correlate with neither increased or decreased rape myth acceptance. Scores flattened out and indicate no improvement with increasing years in the department. A distinct pattern was not discernible; RNs who had worked 12 years in the

department reflected the same degree of acceptance as RNs who had worked 18 (Table 5).



The clearest results identifying a correlation between experience and rape myth acceptance was the experience working with rape victims. The more experience a nurses had working with rape victims, the less rape myth acceptance the nurses demonstrate (see table 6). The 19 nurses who indicated that they seldom saw victims (5 0r less a year) scored between the 5,8 and 6,2 range. One nurse at the 33 victim stage scores lower but, being one person is inconclusive. Nurses in the 100 and more victim range score considerably higher, although they continue to rate the dubious victim lower, and one person scores a 6.2 on the "real" rape victim. RNs in this

category are also few (only 4) but because they consistently score higher, experience working with victims does appear to correlate with lower rape victim acceptance.

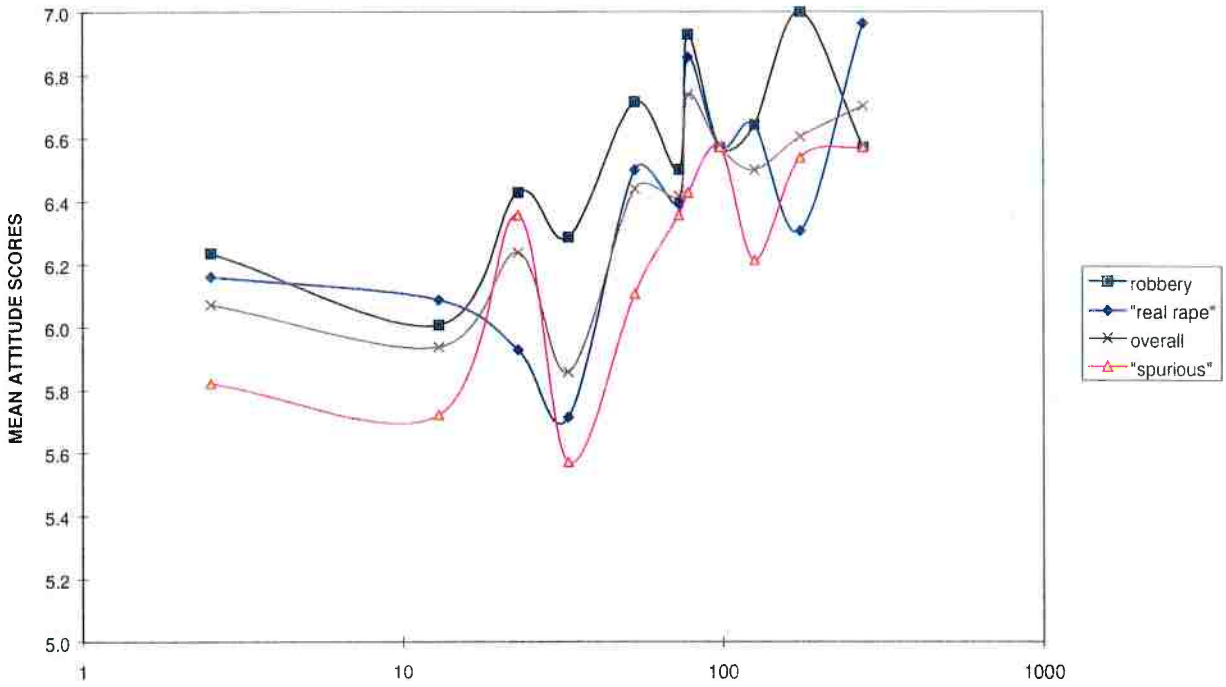


TABLE 6 **NUMBER OF VICTIMS SEEN**

Results of the fifth and final question, "How does training affect rape myth acceptance?" was inconclusive (Tables 7a, 7b and 7c). Unanticipated by the principal investigator, the questionnaire category of 25 hours or more of training could not be charted on the scatter plot table. Since this range did not have an end point, the mid point could not be determined. Consequently, the six participants with this answer were eliminated.

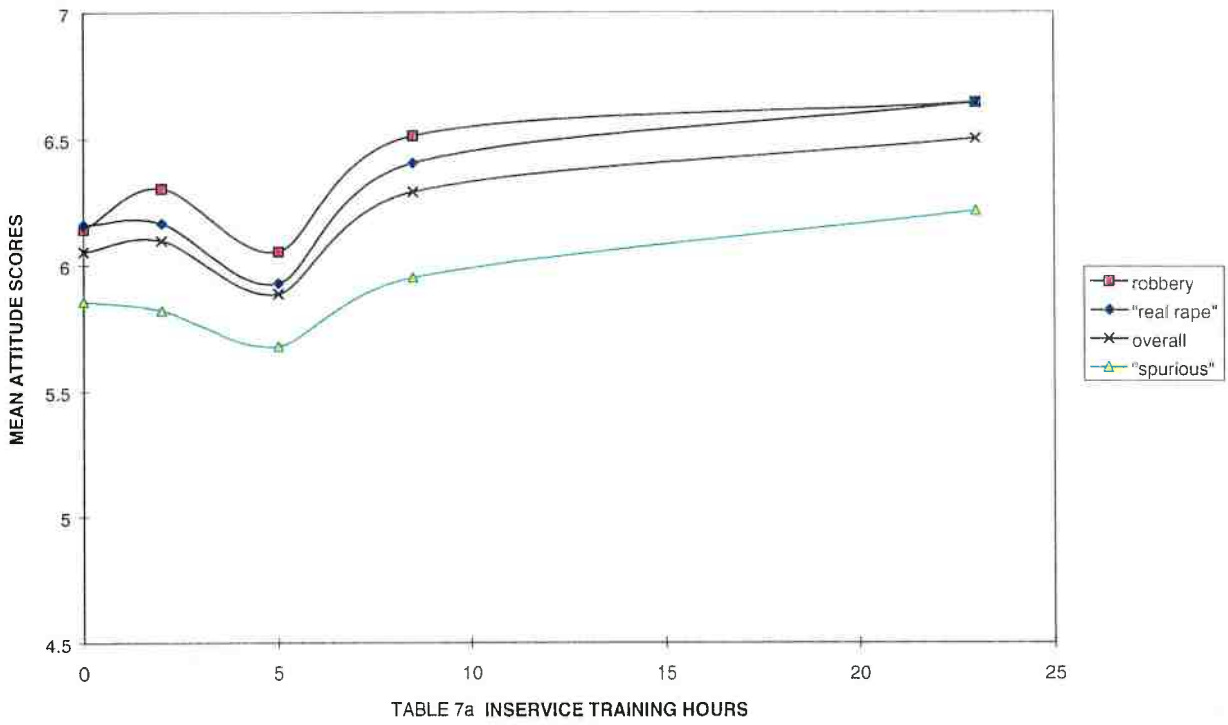


TABLE 7a INSERVICE TRAINING HOURS

The scores for the category on literature were primarily even (Table 7b). At the ten item point, one person scores 5.1 on the dubious victim. Myth acceptance decreases for one RN regarding the robbery victim at the 20 hour point, but since robbery is not the topic of the articles, this does not clearly reflect an impact created by the content. Most scores fall within the same range or create such a curvy pattern that significance is difficult to determine. What the results did indicate, however, was that only 5 of the RNs read more than 6 items of related literature. The other 26 nurses read under 6 items of literature. However, according to these results, whether reading more significantly changes attitudes is inconclusive since they are fairly high (6.5) to begin with.

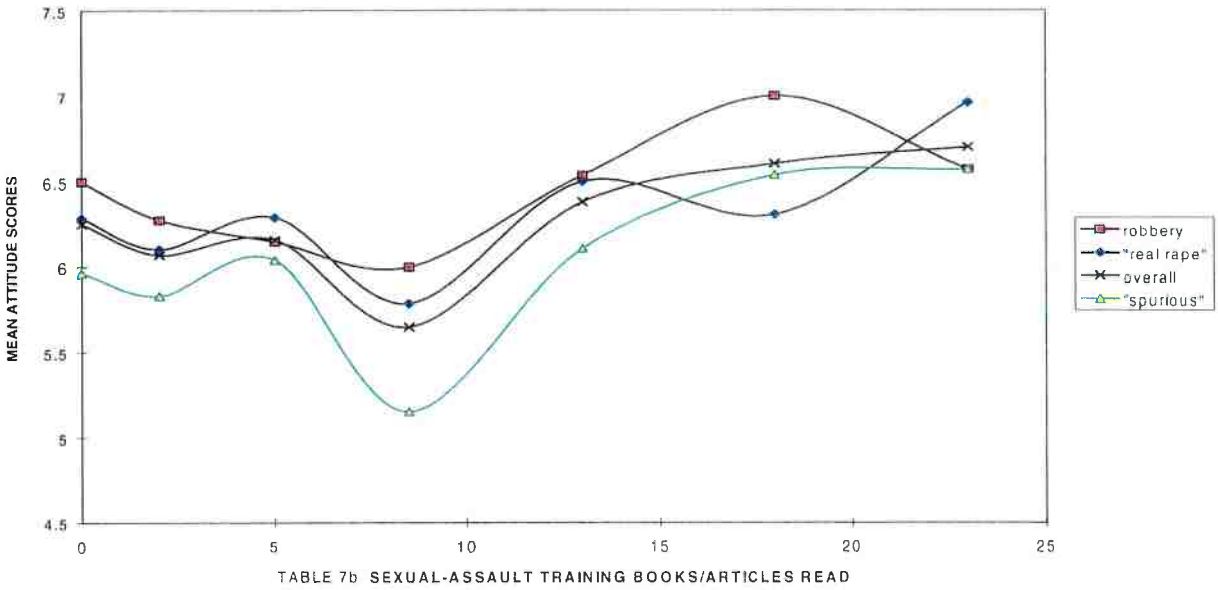


TABLE 7b SEXUAL-ASSAULT TRAINING BOOKS/ARTICLES READ

The category on informal training such as movies and TV shows was inconclusive (Table 7c). The attitudes are in the 6.0 range in initially with 24 nurses. Attitudes increase slightly with more in formal training but this is reflected by only 2 RNs. Then attitudes decrease, but this again is as a result of 2 respondents.

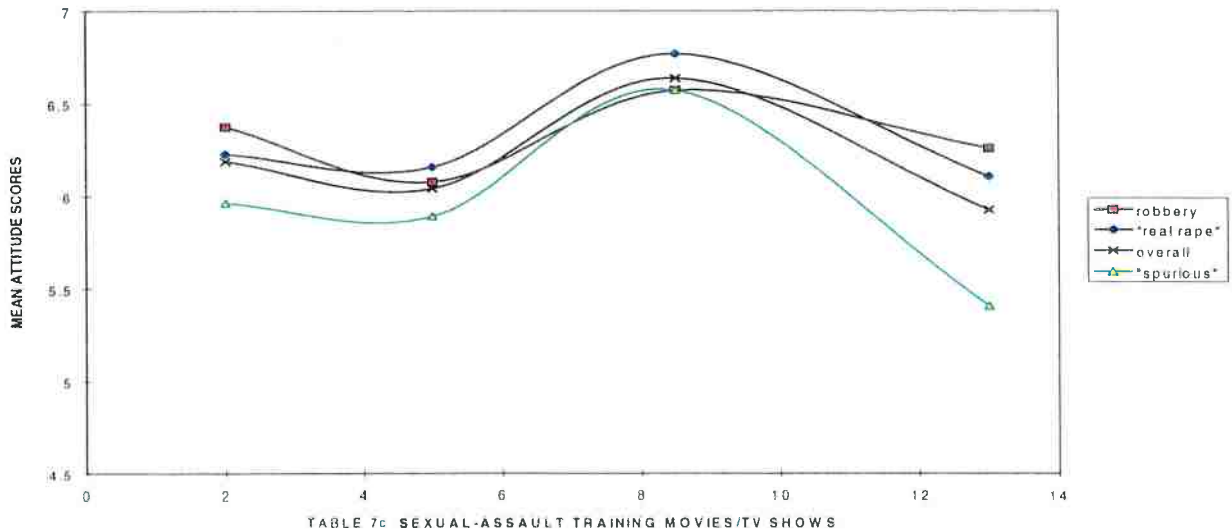


TABLE 7c SEXUAL-ASSAULT TRAINING MOVIES/TV SHOWS

CHAPTER V. DISCUSSION

COMPARISON OF FINDINGS TO THE LITERATURE REVIEW

Findings from this study are consistent with the literature indicating that professionals, along with most other people, support rape myths. Since few studies exist regarding nurses specifically, a direct comparison is difficult. Results from the one study available do differ from those found here. Alexander (1980) reported that the more experience a nurse had working with victims, the more responsibility they attributed to the victim and the more they ascribed to rape myths. This finding is in direct contradiction with findings from this study. Except for an initial regression, the more experience a nurse had, the less she believed in rape myths in this study.

Comparison with the literature review is difficult. Most of the other studies measured attributes of the observer or respondent, while this study measured responses toward attributes of the victim. For instance, many of the studies examined characteristics of the observer such as internal or external locus of control, "just world" theory and previous experience with assault. The intention was to determine not only if the respondents attributed responsibility to the victims, but also what type of respondent was most likely to do so. Other than demographics, this study did not examine characteristics of the respondent.

In comparing the occurrence of victim blaming, the findings in this study are similar to those in the literature: The RNs do demonstrate rape myth acceptance as do nurses, police officers and other professionals in the previous studies. In comparison to studies that measure characteristics for which victims receive blame, as demonstrated

in Burt (1980) and Feild (1978), the findings in this study are similar. Characteristics such as expecting the woman to have fought more, or that she somehow could have prevented the assault, are rape myths identified by Burt (1980) and Feild (1978) and incorporated into the dubious rape. Other rape myths accepted by the respondents, such as being less desirable after an assault, instigating the assault by walking to her car alone at night, and having an unconscious need to be victimized, were also similar myths identified by Burt and Feild. Respondents in each of the studies accepted similar myths.

Findings in this studies indicated that all but two respondents attributed more blame to rape victims than to the robbery victims. The research in the literature conflicted with this finding. Some researchers, such as Feild (1978), Burt (1980), and Best et al. (1992), found this to be true. Others, such as Alexander (1980), reported that professionals did not distinguish between victims of different types of crimes.

FURTHER DISCUSSION OF FINDINGS

One of the primary findings of the study is that the nurses scored higher than the medical students in the Best et al. study (1992). The hypothesis further stated that a difference in scores can be attributed to the differences in experience and training between medical students and practicing nurses. However, when we examine those two categories independently, the results are mixed. Instead, the reason nurses scored higher in this study than medical students in the South Carolina study could be attributed to a number of other factors.

A major reason nurses in this study could have judged victims less harsher than the medical students could be because of gender differences. Very few males participated in the nurses' study, whereas the majority of medical students were males. As the literature indicated, gender and sex-role stereotyping (which correlated with gender) was a primary correlate to rape myth acceptance.

Another factor influencing the scores could be regional differences. The medical student study was conducted in the South whereas the nurses' study was conducted in the Midwest. Rather than measure anything thing else such as the affect of experience or training, this study could be measuring the affect of southern culture as opposed to Midwestern culture. Perhaps Southern culture in general supports rape myth acceptance more.

Yet another influence could be chronological. The medical students were surveyed in 1982 whereas the nurses were surveyed in 1996. Societal changes occurring within those years could influence the scores. For whatever reason, nurses in this study demonstrated significant improvement in rape myth acceptance over the medical students.

Experience in working with victims appeared to be a key factor in minimizing responsibility attribution of rape victims. Although only 4 nurses worked with 100 victims or more, each of them demonstrated low myth attribution. While the underexperienced nurses were not exceptionally high in attribution, other factors not introduced in this study such as comfort working with victims and the criminal justice system also increase with experience allowing the RN to practice more effectively.

LIMITATIONS OF THE STUDY

Because the study is cross sectional and non-randomized, results may not generally apply to all hospitals. This hospital also has a specialized unit of nurses who conduct the sexual assault exams. Therefore, Emergency Room (ER) RNs are not directly exposed to as many victims of sexual assault as other ER RNs. On the other hand, the ER RNs may benefit indirectly from the specialized information disseminated by the specialized nurses in the course of conducting an exam, thereby giving them an advantage over other RNs. Determining the exact effect of these unique circumstances is difficult; however, they should be considered when interpreting the results.

Another limitation is the small sample size. While somewhat adequate to obtain a certain amount of information, a population of 38 is relatively low. Another barrier to obtaining statistical significance is that a test was not conducted in which the null hypothesis can be rejected. The Best et al. study was able to conduct an ANOVA bivariate analysis using gender as one of the factors. Because the IRB prohibited this principal investigator from asking that gender be identified because of the perceived risk to the low male population, this test cannot be conducted similarly in this study. A control group was not utilized to compare findings, nor were measures taken to ensure external validity; therefore, the results can not be generalized to other populations.

In attempting an attitudinal survey, the researcher runs the risk of interference from social desirability in which subjects report what they determine is appropriate to say rather than what they truly think. Such could be the case for this study, although rape myth acceptance was high enough to indicate the majority of participants gave

candid rather than manufactured, responses. Some modification could have taken place nonetheless. This aspect does not render the study useless since measuring socially desirable responses reveals about how far society has progressed in identifying rape myths. If people can identify rape myths and determine they are unacceptable even if they believe them, this is an educational accomplishment.

It is unfortunate fact that because of their minute number, male responses could not be compared to female responses as in the Best et al. study. It is particularly unfortunate since most of the literature indicates gender and sex role stereotyping closely correlates with rape myth acceptance. Because of this limitation, valuable comparison of information is not available. Recommendations for future studies would include a purposive sampling of males to allow comparison within any given population.

Because of low representation and the risk factor, this study also did not address cultural influences. Because rape myth acceptance is a function of sex role stereotyping, which exists to varying degrees in different cultures, a cultural comparison would have brought forth useful information. A significantly diverse population would have been needed in which to make such information non-stereotypic and statistically useful.

A strength of this study is that it is one of the few conducted so recently. As stated, similar surveys were conducted in the late 1970s and 1980s. Another strength of this survey is that the respondents were professionals rather than students as used in the preponderance of studies. Although professional treatment toward victims is the focus, professionals are seldom the population surveyed, probably because of limited time and accessibility. While students represent a useful and accessible population,

their response does not indicate what reactions actually occur in the field. This investigator was fortunate because the hospital was so receptive to participating.

Both a strength and a limitation of this study was that it was conducted with RNs and not social workers. The limitation is that this is an masters in social work (MSW) thesis and social workers would have been the reasonable population. Unbeknownst to the principle investigator at the outset, it would have been the only known study conducted among social workers. An advantage of the study is that is it does form a bridge that did not exist before. Because it was conducted among RNs by an (MSW) student, it does form a bridge between the two disciplines and breaks new ground on this topic. The principal investigator, having had many years experience as a rape counselor working among professionals in the medical field, was interested in identifying and substantiating the myth acceptance she had experienced among RNs over the years and felt it would be useful information for social work practitioners.

CHAPTER IV. CONCLUSIONS AND RECOMMENDATIONS

IMPLICATIONS FOR SOCIAL WORK PRACTICE

The implications from this study for social work practice are many. On a micro level, the information can assist a social worker in helping the client. Although the medical field may seem removed from regular social work practice, many clients have intersecting experiences with professionals in both fields particularly after a sexual

assault. Because first respondents play such an important part in charting the course of the healing process of rape victims, it is imperative for social workers to be apprised as to how the medical field responds. How the victims are treated determines if they will either go on further in seeking help or if they will suppress reactions and not seek help.

When victims suppress the assault, they usually manage their pain through dysfunctional or self-destructive coping mechanisms such as depression, suicide attempts, or substance abuse. Often this behavior leads to involvement with social services, in which case the worker is forced to deal not only with the assault but the tertiary problems it has caused. Often the female is a parent whose maladaptive coping mechanisms may put her children at risk. Clearly, dealing with the assault before it is suppressed is most beneficial both for the client and the worker involved.

On a macro level, it appears that rape myth acceptance, attributing responsibility to the victim, or victim-blaming are common occurrences. Although the RNs do represent a sub-group, they also are part of the larger portion of citizenry and are very much the product of our culture. Therefore, the population at large creates an unsafe climate for victims seeking assistance and understanding. Since one of social worker tasks is to be involved in social issues, how professionals treat victims should be of concern.

Implications for social change are revealed, particularly in the literature review. According to the literature, social change in rape myth acceptance will be difficult and complicated. One of the primary causes of rape myth acceptance lies within the social psychological structure of our culture in the area of sex role stereotyping, gender roles,

and adversarial sexual roles. For instance, learning to accept and celebrate female sexuality, rather than believing in a double standard and forcing women to conform, is difficult. In protecting women from rape, undoing belief systems is a much more difficult task than just teaching women to lock their doors at night as a precaution. Therefore, in order to accomplish social change on a macro level, workers will need to be patient and tireless in their pursuit.

RECOMMENDATIONS FOR POLICY, PRACTICE, AND FUTURE RESEARCH

Evidence from this study and those examined in the literature review indicate that rape myth acceptance still exists among professionals. Literature also indicates that rape myth acceptance seriously impedes victim's recovery process. In addition to preventing rape in the first place, changing how professionals respond to victims of rape is also beneficial.. Rather than inflicting secondary victimization, professionals need to receive proper training in order to respond appropriately.

Training does not currently exist within the nurses' training or the medical school curriculum. Neither nurses or doctors receive systematic training on how to respond appropriately to sexual assault. It is impractical to expect professionals' attitudes and responses to change when training practices have not. One recommendation would be to offer training to students in their course work and continue to administer skill development inservices throughout their practice. Policy should require that all legal and medical professionals receive a certain number of course credits in school and inservice hours afterward in the area of sexual assault treatment.

Hospitals should take note that experience in working with victims was a significant correlant in reducing acceptance of rape myths and develop policy accordingly. Few nurses are able to get extended contact working with victims in all but the busiest hospitals. The norm is for a nurse to see only one or two victims a year in their practice. Therefore, creating a program such as the SARS program would be beneficial. This program consists of nurses specially trained to treat rape victims and conduct exams. A small number of nurses are on call to conduct all of the exams; therefore, they are able to become quite proficient in treating victims. Since evidence indicates that nurses with the most experience working with rape victims attribute the least responsibility, rural or isolated hospitals should address the inexperience of their nurses by developing a SARS program or making arrangements to utilize a larger hospital when treating rape victims.

Since sexual assault is a social issue, social workers should examine the practices of their hospitals and law enforcement departments to be certain that skills among these professionals are updated. Furthermore, when a client reports incompetency or victim blaming treatment from any of the service providers, social workers should follow up to remedy the situation. In addition, social workers should also be required to receive similar training in order to ensure their own reactions to victims are appropriate.

The most comprehensive and effective change will need to come by changing our culture. Since research indicates a high correlation between rape myth acceptance and sex role stereotyping, the most effective change will be accomplished through the dismantling of these beliefs. Therefore, change must be accomplished

comprehensively through our schools to children at an early age. Gender fair information must infiltrate all curriculum. Gender fair treatment must be incorporated into all policy and practices in our government, workplaces, and schools (Thornton, Robbins & Johnson, 1981).

Topics of further research would be to replicate some of the very fine studies that took place in the 1960s and 1970s to determine if attitudes have changed among professionals. Without a proper assessment, training may be ineffectively directed based on out dated information of what the needs are. A population never addressed would be that of social workers and how they perceive victims. Another topic yet to be addressed, is to interview victims themselves to ascertain how they felt they were treated by professionals. This would eliminate the social desirability factor and respondents reporting what they think is right but acting a different way in practice. Victims themselves would be a key informant in identifying attitudes among professionals.

CONCLUSION

This study was worthwhile. The findings supported the literature and other studies. Duplicating the South Carolina study indicated that statistically more positive attitudes are present in practicing RNs compared to the medical students in the Best et al. study (1992). Although how these improvements were accomplished was not identified, it nonetheless is a cause for hope. It continues to alarm the principle investigator that blatant rape myths are still accepted even to some degree.

Reasons for blaming victims lie both in the respondents personal make-up and in our culture. Different types of respondents, such as internally controlled versus externally controlled individuals or gender role specific individuals, are prone to believing rape myths than are others. This means that successful change must be tailored according to the types of respondents. The area for change that should be undertaken, although long term, would be to alter the aspects of our culture that contribute to rape. This would take an immense and all encompassing effort. Being aware of the need for change, as stated by Check & Malmuth (1983), is at least a beginning.

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APPENDICES

APPENDIX A

February 13, 1996

Nancy Steblay, PHD
Institutional Review Board Chairperson
2211 Riverside Avenue, Campus Mail # 32

Re: Barbara J. Kiffe MSW Candidate

Dear Dr. Steblay,

We are writing to you on behalf of Barbara J. Kiffe, MSW graduate student at Augsburg College. Barbara will be conducting a research study with our Crisis Center, Sexual Assault Resources (SARS), and Emergency Department nurses entitled "Nurses' Perceptions: Responsibility Attribution of Rape Victims." We know this information will be a valuable source of information for helping rape victims, and we give Barbara our enthusiastic support and appreciation for choosing this topic.

Barbara has our permission to conduct a survey among our nursing staff utilizing a questionnaire. We understand that the anonymity of each participant as well as that of our hospital will be protected.

Please feel free to contact me at (DELETED) if you have questions.

Sincerely,

(DELETED)	(DELETED)	(DELETED)
Clinical Director	Nurse Manager	Director SARS

APPENDIX B

May 21, 1996

Dear Nursing Staff,

I am a graduate student working toward a Masters in Social Work Degree at Augsburg College in Minneapolis, Minnesota. For my thesis, I am researching the impact experience and training has on your perceptions of sexual assault and other types of crime victims. You were selected as a possible participant because your department has contact with victims initially after their assault. This research study has been approved by and is being done in cooperation with (DELETED).

Your experiences and opinions are important! Your participation in this study is entirely voluntary and will not affect your current or future status with the (DELETED) or Augsburg College. While you receive no direct benefits for participating, your expertise will help assess caregiver's perceptions with the long term goal of upgrading services for victims.

The research instrument consists of three vignettes, two rape victims and a robbery victim, with an accompanying questionnaire for each. It is a one-time commitment on your behalf and will take approximately ten (10) minutes to complete. Respondents will be kept anonymous. Information from the questionnaire will be used for my thesis which will be shared with the hospital and with Augsburg College. Neither the hospital nor the departments will be identified in the research results. Completion and return of this questionnaire indicates your consent to participate.

A risk in participating in this study is that you may be reminded of feelings or experiences associated with sexual assault, either your own or that of a patient's. You may skip any questions that feel uncomfortable without necessarily dropping out of this research study. In the event that this questionnaire produces emotional distress, please contact the Sexual Violence Center at 871-5100 and support services will be provided as needed.

I am surveying RNs from the Crisis Center, Sexual Assault Response Services (SARS), and the Emergency Department (ED) during the month of May 1996. If you chose to participate, I ask that you fill out the questionnaire, and either return it in the enclosed self-addressed stamped envelope or in the designated mailbox.

Please fill out and return by May 30, 1996.

Thank you for your assistance. If you have any questions, you may contact my thesis advisor, Maria Brown (330-1771), Jackie Capitski (347-3132), or Linda Ledray(347-5832).

Barbara J. Kiffe

IRB# 95-57-3

APPENDIX C

BACKGROUND INFORMATION SHEET
(PLEASE DO NOT PUT YOUR NAME ON THIS SHEET)

I AM AN RN YES NO
ATTENTION: If your answer is NO, do NOT continue!

Number of years worked in the department

O-2___	6-8___	12-15___	21-25___	31-35___
3-5___	9-11___	16-20___	26-30___	36-40___

Number of years since graduation from nurse's training:

O-2___	6-8___	12-15___	21-25___	31-35___
3-5___	9-11___	16-20___	26-30___	36-40___

TRAINING AND EXPERIENCE

I. Sexual assault training:

A. Inservices: approximate number of hours atttended in last three years

1-3 4-6 7-10 11-15 16-20 21-25 MORE

B. Literature: approximate number of books, articles read in last three years

1-3 4-6 7-10 11-15 16-20 21-25 MORE

C. Informal training: educational movies or TV shows regarding sexual assault approximate number seen in last three years

1-3 4-6 7-10 11-15 16-20 21-25 MORE

II. Number of victims you have worked with (provided exams and/or counseling)

approximate number for the last three years

0-5	**11-15**	**21-25**	**31-35**	**41-45**	**51-55**	**61-65**	**71-75**	**81-85**	**91-95**
6-10	**16-20**	**26-30**	**36-40**	**46-50**	**56-60**	**66-70**	**76-80**	**85-90**	**96-100**

MORE THAN: 100 150 200 250 300 350 400 450 500 550

Patient 1

Read the following patient description and record your responses on the next page

A nineteen year old, attractive, white female presents to the emergency room stating that she has been raped. Patient is attired in jeans and a blouse with several tears in her clothing. Patient appears to be emotionally distressed. Her speech is articulate, coherent, but sometimes interrupted by episodes of crying. Patient states that she had stayed at the university long enough to go out with female classmates for one drink before heading home. As she walked alone to her car in an unlighted parking lot, she was approached by a man. Patient reports that the man said he was going to rape her and told her he would harm her if she screamed. Patient did not see a weapon, however. Patient reports he had raped her, tore her blouse slightly in the process, and then walked away. He also forced her to have oral intercourse. She states that she came to the emergency room immediately. Patient is oriented x3. Her intelligence appears to be average.

For each of the following, write in the blank beside the statement a number from 1 to 7 corresponding to the degree to which you agree or disagree with that statement.

Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

1. This woman was responsible for preventing the assault. ____
2. This woman provoked the assault by her appearance. ____
3. This woman provoked the assault by her behavior. ____
4. This woman was an innocent victim. ____
5. Women who walk to their car alone, at night, are asking for it. ____
6. This woman , to some extent, could have prevented the assault. ____
7. This woman may have reported the assault for "attention." ____
8. The likelihood that this woman was fabricating the story to get back at someone is extremely low. ____
9. Some women have an unconscious wish to be victims and then may set up a situation in which they are likely to be assaulted. ____
10. Assuming this woman was healthy before the assault, she could have been more successful in resisting the assault if she had wanted to. ____
11. The fact that this woman may lead a wild or promiscuous lifestyle, wouldn't figure into the believability of her report. ____
12. The lack of signs of more visible trauma makes this woman's story slightly less credible. ____
13. This woman is less desirable than other women after the assault. ____
14. Had this woman been my neighbor, I would not feel any differently about the credibility of the story. ____

Patient 2

Read the following patient description and record your responses on the next page

A twenty year old white female presents to the emergency room stating that she has been a victim of a robbery. Patient is complaining of minor abrasions on her knee and forearm. She states that she received the injuries in the process of the robbery. Patient reports being approached from behind by an unidentified male approximately 25-30 years old as she walked to her car. According to the patient, the assailant tried to grab her purse from her arm. The assailant was initially unsuccessful in the attempt to get the purse free, and the patient states she then began to scream. Patient reports that she struggled with the man which resulted in a scrape to her arm. She also reports that she received an abrasion to her knee but isn't quite sure when that occurred. Patient is attired in a skirt and sweater. She appears moderately anxious. Her rate of speech is somewhat fast, but coherent. However, the patient is oriented x3. She is of at least average intelligence.

For each of the following, write in the blank beside the statement a number from 1 to 7 corresponding to the degree to which you agree or disagree with that statement.

Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

1. This woman was responsible for preventing the assault. ____
2. This woman provoked the assault by her appearance. ____
3. This woman provoked the assault by her behavior. ____
4. This woman was an innocent victim. ____
5. Women who walk to their car alone, at night, are asking for it. ____
6. This woman , to some extent, could have prevented the assault. ____
7. This woman may have reported the assault for "attention." ____
8. The likelihood that this woman was fabricating the story to get back at someone is extremely low. ____
9. Some women have an unconscious wish to be victims and then may set up a situation in which they are likely to be assaulted. ____
10. Assuming this woman was healthy before the assault, she could have been more successful in resisting the assault if she had wanted to. ____
11. The fact that this woman may lead a wild or promiscuous lifestyle, wouldn't figure into the believability of her report. ____
12. The lack of signs of more visible trauma makes this woman's story slightly less credible. ____
13. This woman is less desirable than other women after the assault. ____
14. Had this woman been my neighbor, I would not feel any differently about the credibility of the story. ____

Patient 3

Read the following patient description and record your responses on the next page

A twenty year old, attractive, white female presents to the emergency room. She does not appear to be in acute emotional distress, as she sits quietly and looks out of the window waiting to be seen. She is neatly attired in what appears to be fresh clothing. Hear hair is neatly combed. Rate of speech for the patient is slow, but in logical sequence. Patient states that earlier this evening she was made to have sexual relations with a man. Patient reports that she had come into contact with the man initially through the personal ads and had met once at a local bar. Patient states that this evening she was walking home from the same bar after having one beer when the man drove up beside her and offered her a ride home. Patient reports that she accepted the ride with the man whom she said suggested they have sexual relations. Patient states that she did not want to do so but the man restrained her arm and forced himself on her. Patient is oriented x3. She is of average intelligence.

For each of the following, write in the blank beside the statement a number from 1 to 7 corresponding to the degree to which you agree or disagree with that statement.

Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

1. This woman was responsible for preventing the assault. ____
2. This woman provoked the assault by her appearance. ____
3. This woman provoked the assault by her behavior. ____
4. This woman was an innocent victim. ____
5. Women who walk to their car alone, at night, are asking for it. ____
6. This woman , to some extent, could have prevented the assault. ____
7. This woman may have reported the assault for "attention." ____
8. The likelihood that this woman was fabricating the story to get back at someone is extremely low. ____
9. Some women have an unconscious wish to be victims and then may set up a situation in which they are likely to be assaulted. ____
10. Assuming this woman was healthy before the assault, she could have been more successful in resisting the assault if she had wanted to. ____
11. The fact that this woman may lead a wild or promiscuous lifestyle, wouldn't figure into the believability of her report. ____
12. The lack of signs of more visible trauma makes this woman's story slightly less credible. ____
13. This woman is less desirable than other women after the assault. ____
14. Had this woman been my neighbor, I would not feel any differently about the credibility of the story. ____

APPENDIX D

TABLE 1 **DIFFERENCE BETWEEN "DUBIOUS" & "REAL" RAPE VICTIM SCORES**

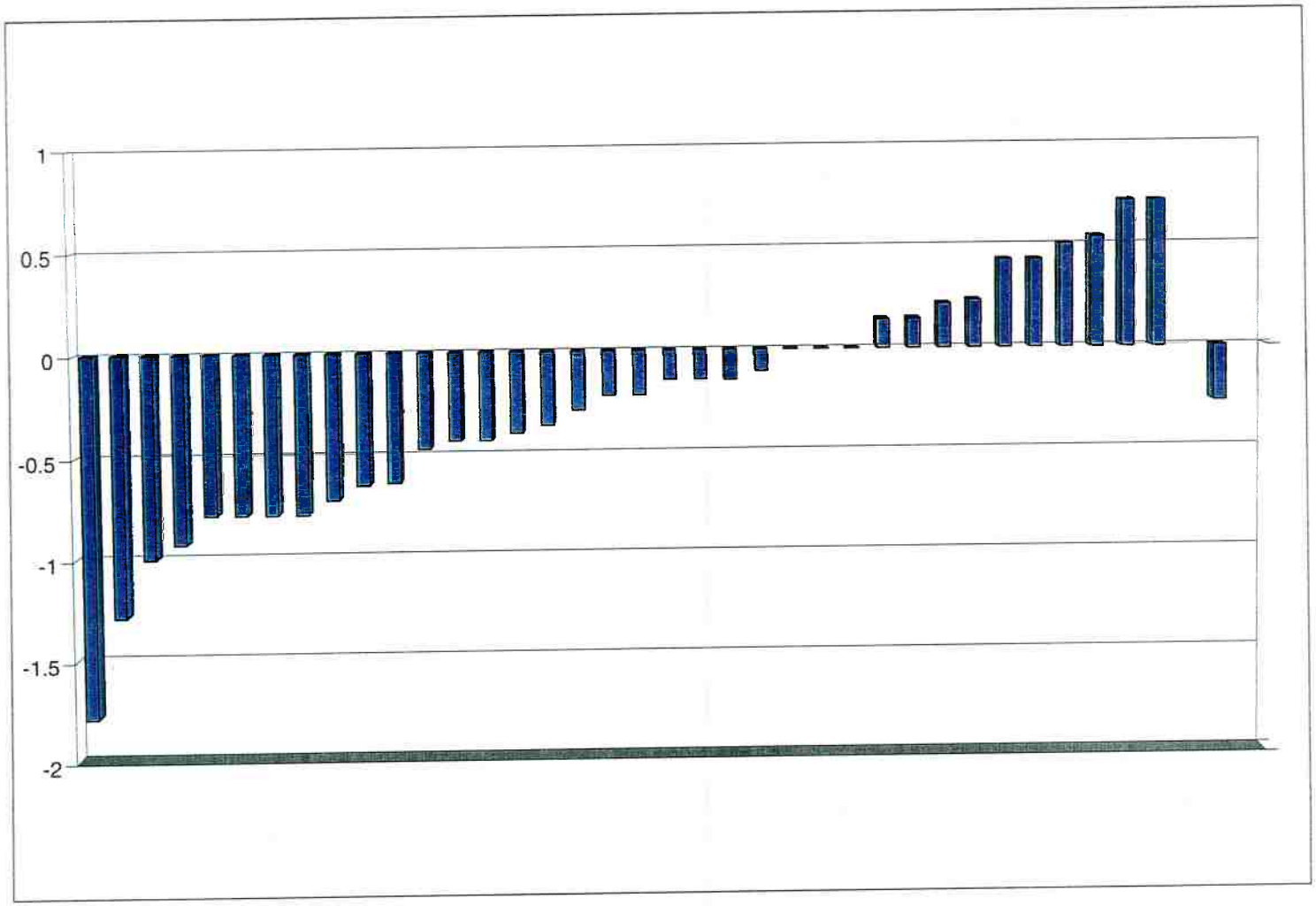


TABLE 2 **DIFFERENCE BETWEEN "DUBIOUS" RAPE & ROBBERY VICTIM SCORES**

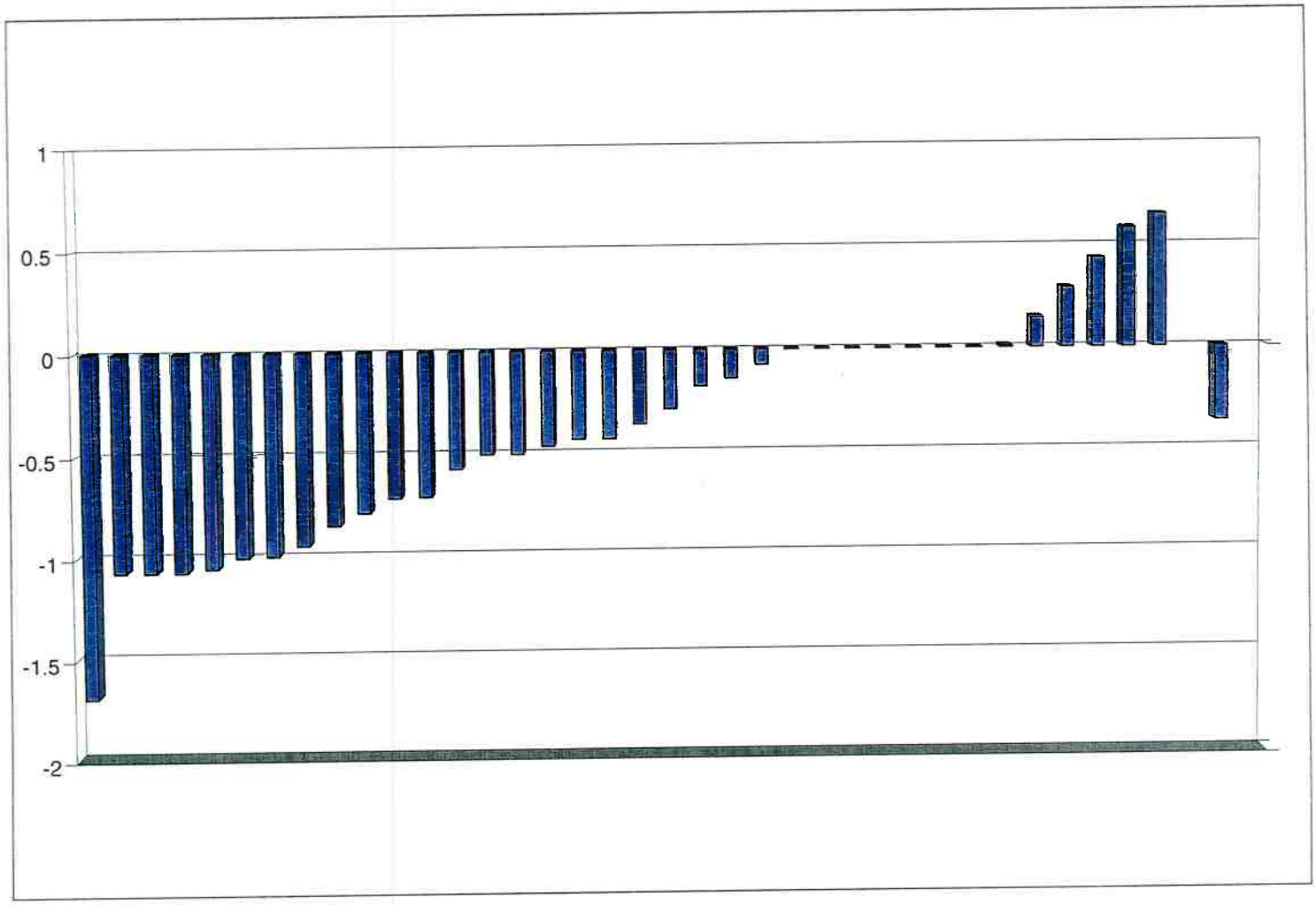
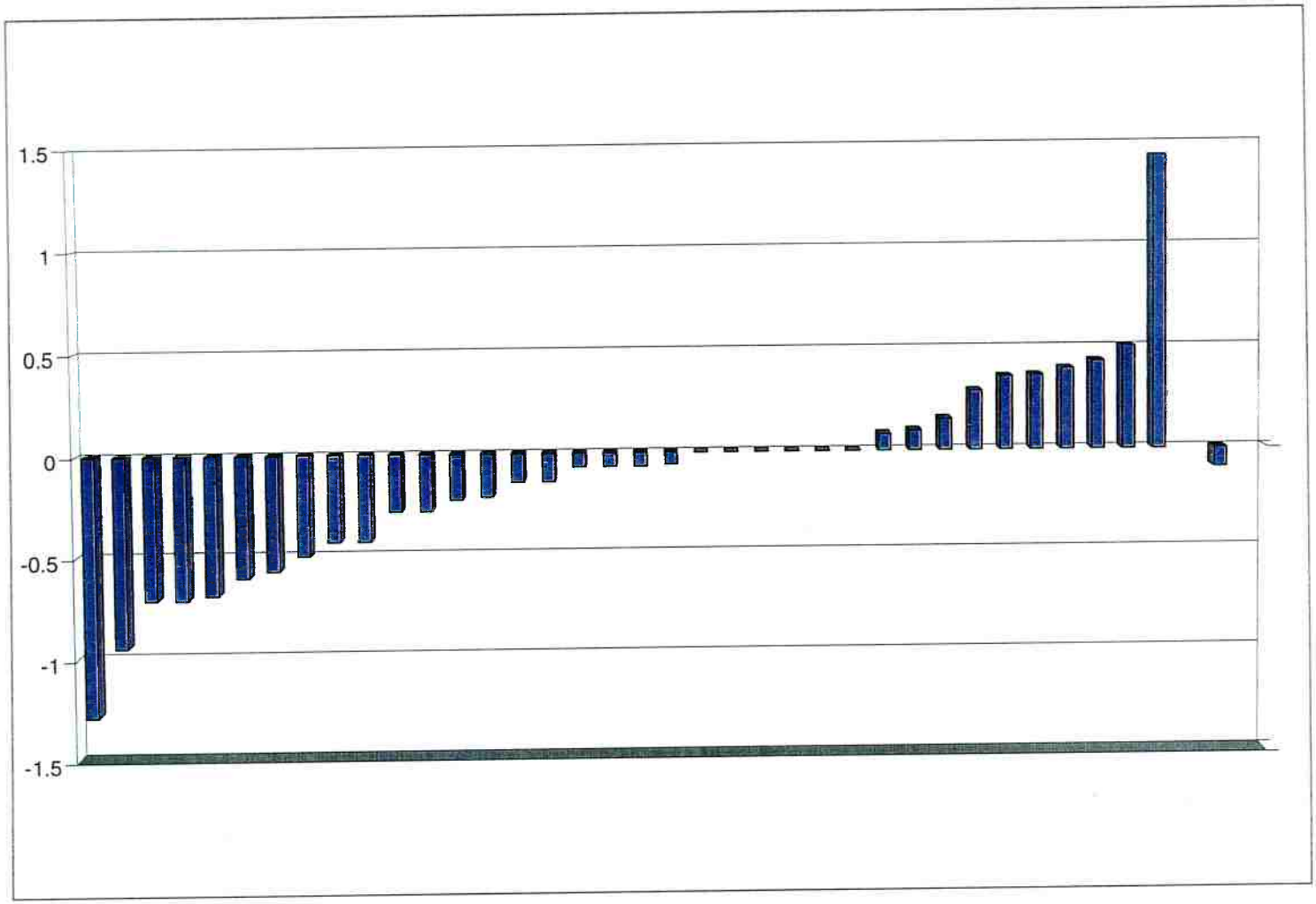


TABLE 3 **DIFFERENCE BETWEEN "REAL" RAPE & ROBBERY VICTIM SCORES**



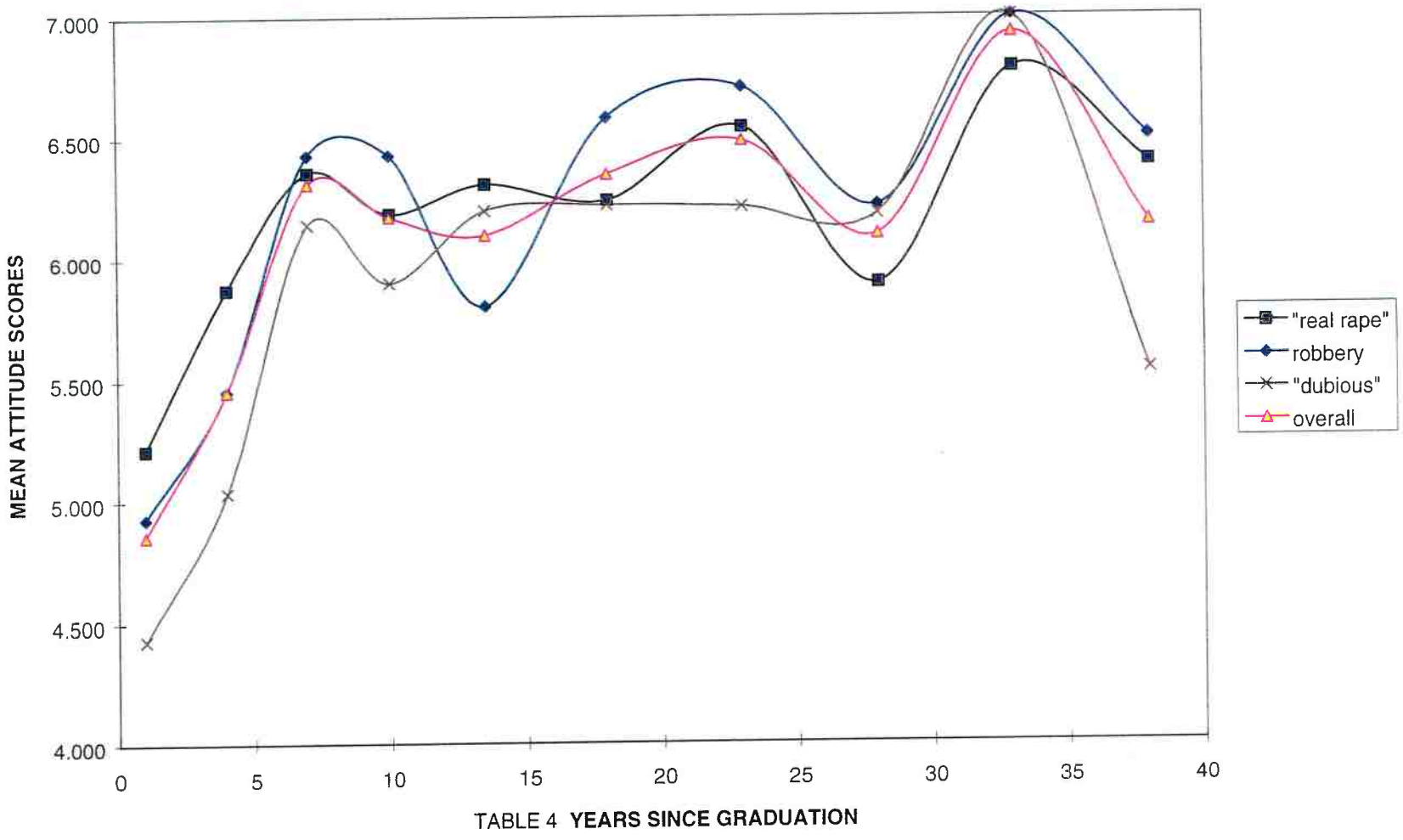


TABLE 4 **YEARS SINCE GRADUATION**

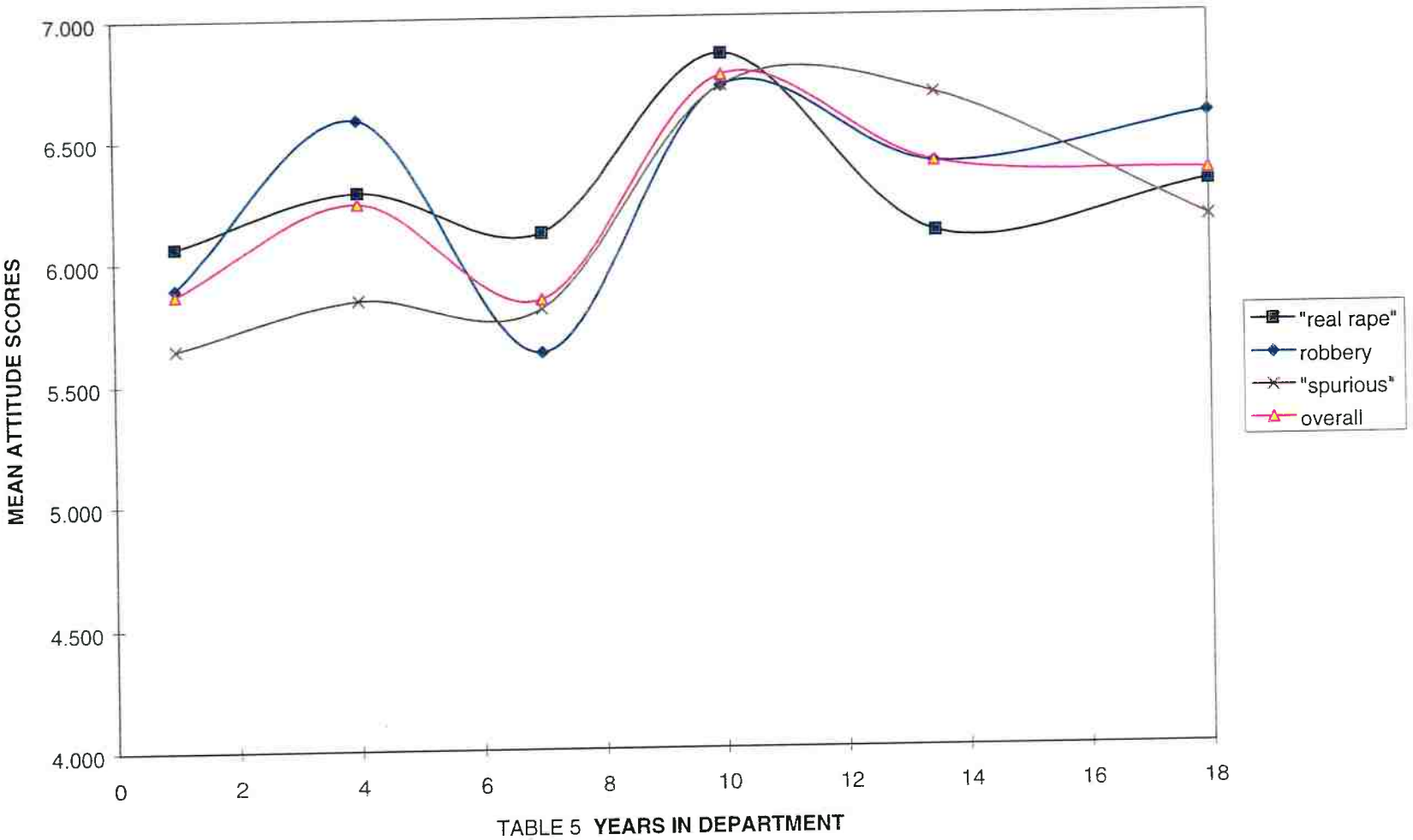


TABLE 5 **YEARS IN DEPARTMENT**

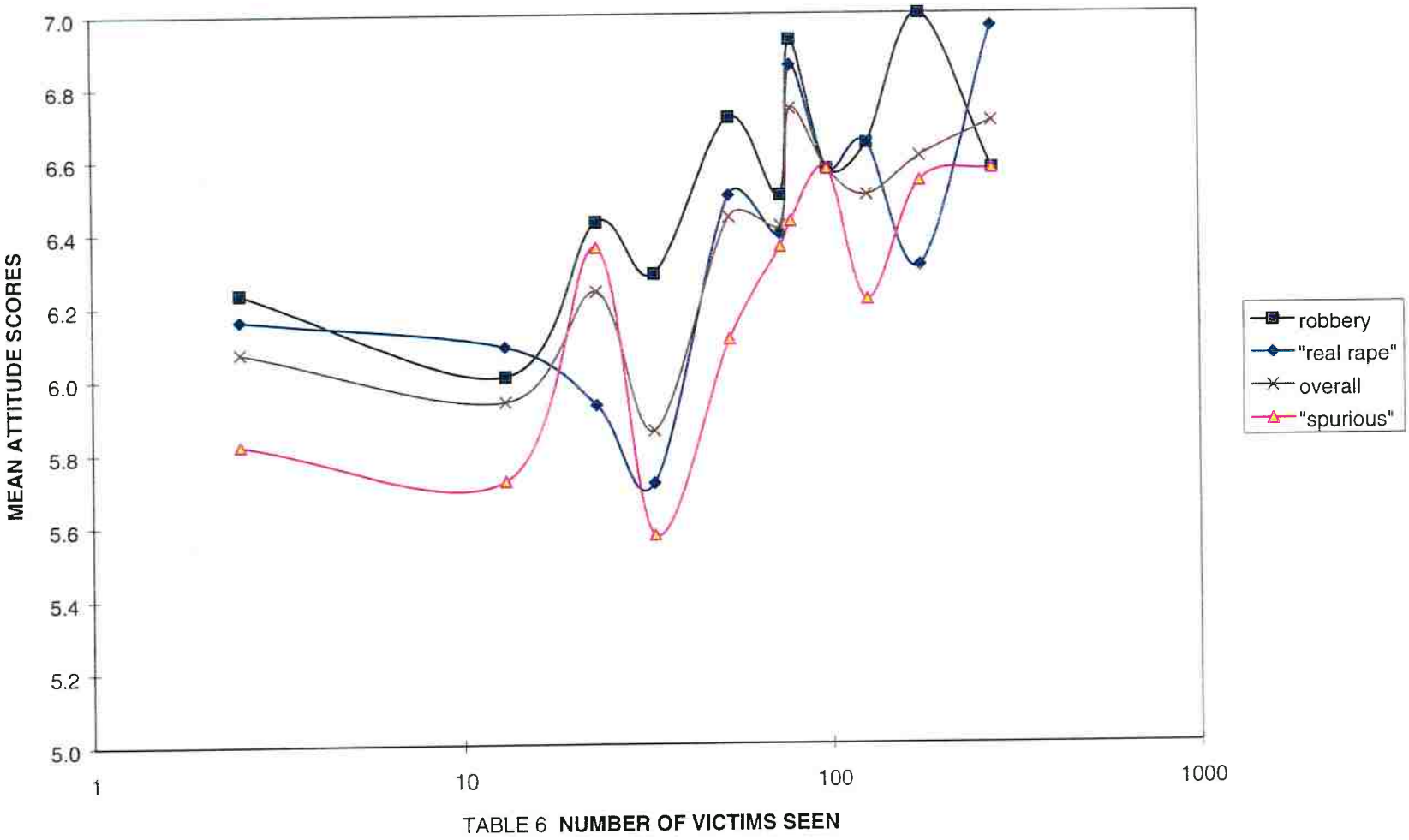


TABLE 6 **NUMBER OF VICTIMS SEEN**

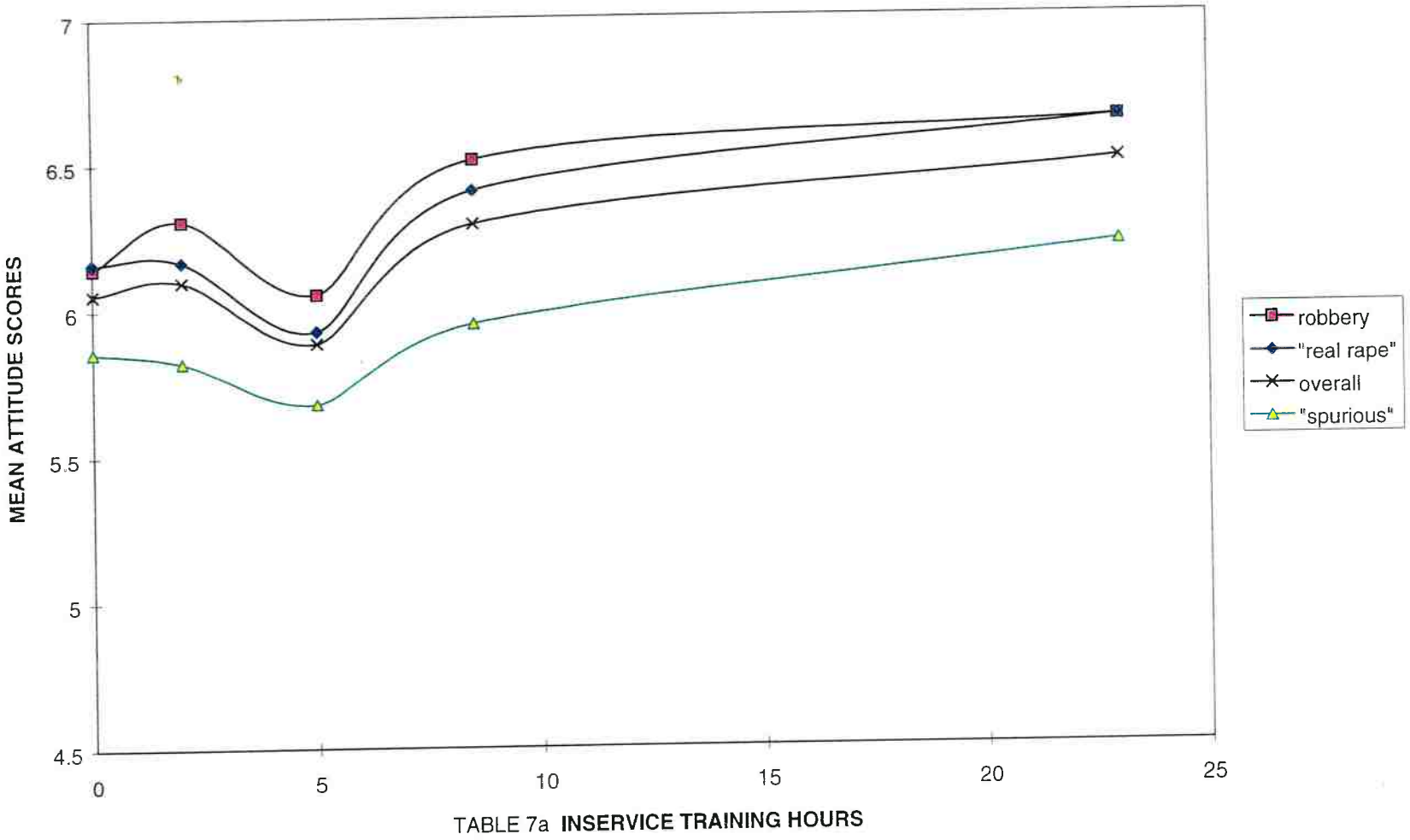


TABLE 7a **INSERVICE TRAINING HOURS**

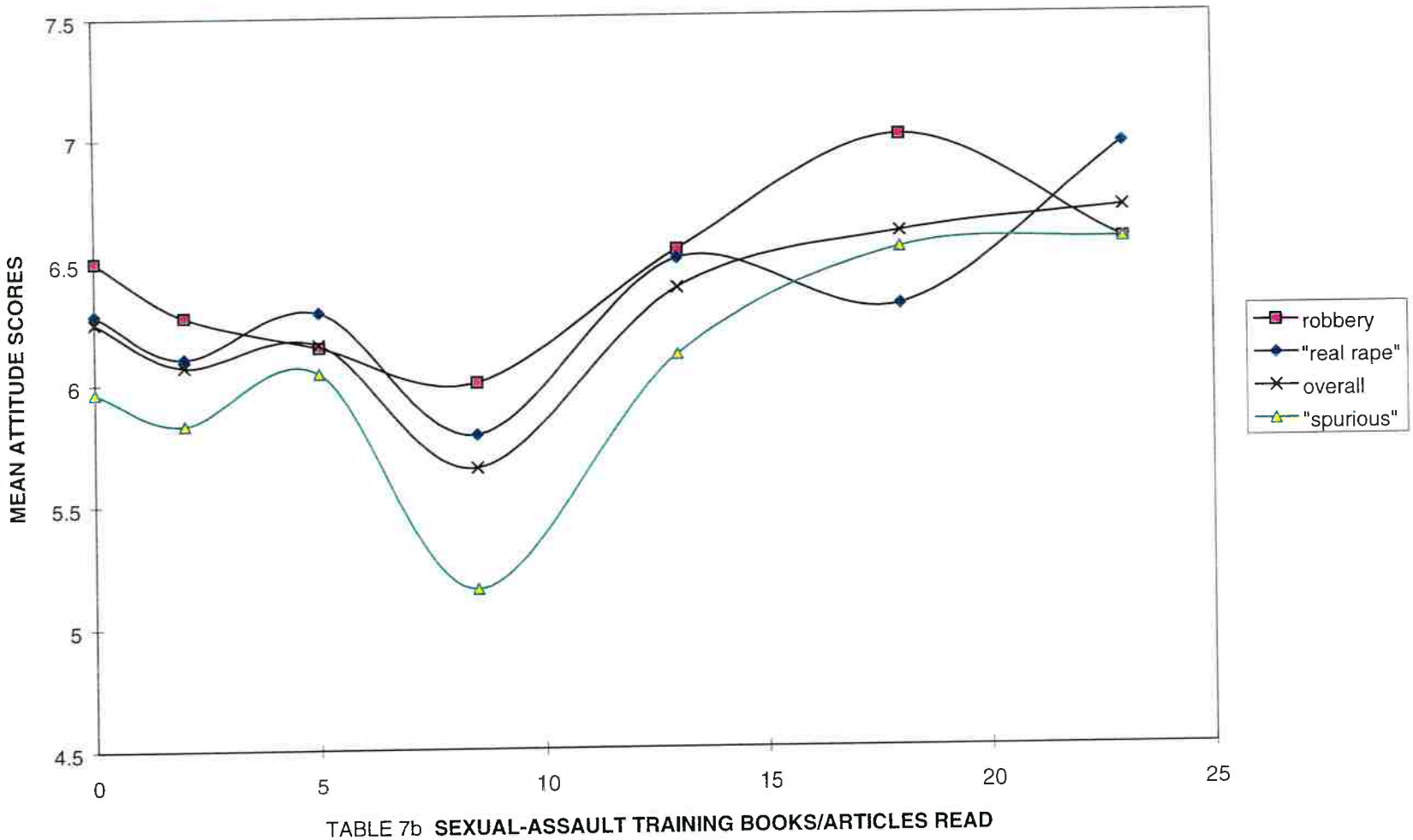


TABLE 7b **SEXUAL-ASSAULT TRAINING BOOKS/ARTICLES READ**

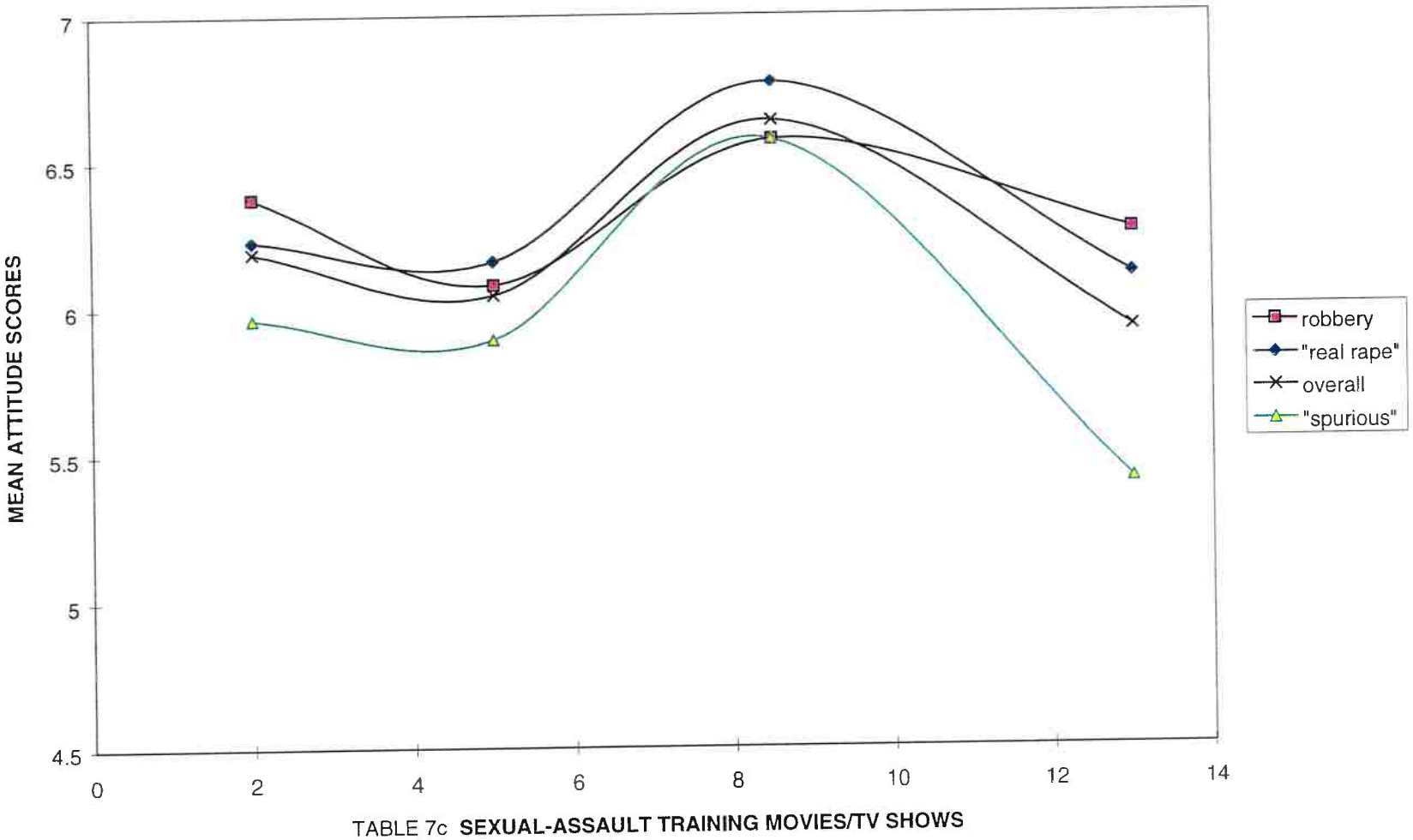


TABLE 7c **SEXUAL-ASSAULT TRAINING MOVIES/TV SHOWS**